Health History

Due Date: June 1 for the fall semester and December 1 for the spring semester. Please submit records one time only.

1. According to NYS Health Law, all students registered for 6 or more credits must provide proof of immunity to measles, mumps & rubella and either receive or decline the meningitis vaccine. Failure to do so will result in withdrawal from class.

2. Immunization information can be obtained from the following sources: your private medical practitioner, high school health office, previous college health services (transfer students), or infant records held by parents that are signed by a physician.

MANDATORY IMMUNIZATION INFORMATION – Please have your physician complete & sign below.

Students born on or after January 1, 1957 must show proof of immunity to measles, mumps and rubella.

Dates of MMR: 1. _______ 2. _______ or titers. Attach a copy of records signed by a Health Care Provider.

I certify that the above immunization record is accurate.

Provider Signature ________________________________ Date: __________________

ALL IMMUNIZATION RECORDS MUST BE SIGNED BY A HEALTH CARE PROVIDER

MENINGOCOCCAL MENINGITIS VACCINE – RESPONSE REQUIRED

REQUIRED — To be COMPLETED and SIGNED by student or parent/guardian for student under the age of 18

☐ I have received the menomune vaccine within the past 10 years. Date: ____________

☐ I have received the menactra vaccine within the past 10 years. Date: ____________

☐ I have received the menvo vaccine within the past 10 years. Date: ____________

☐ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I (my child) will NOT obtain immunization against meningococcal meningitis disease.

Signed: ________________________________ Date: __________________

(Student signature-Parent if under 18)

Please indicate if you have ever had/have the following:

<table>
<thead>
<tr>
<th>Illness</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>1. Asthma/Hayfever</td>
<td></td>
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<tr>
<td>2. Diagnosed Depression/Anxiety/Mood Disorder/Counseling</td>
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<td>3. Diabetes</td>
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<td>4. Seizures/Convulsions</td>
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<td>5. Heart Murmur/Disease/Clotting Disorder</td>
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<tr>
<td>6. Eating Disorder</td>
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</tbody>
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List any surgeries:

List current medications:

8. Allergies to: Food Medication Other if circled, please explain:

Consent for Medical Care:

I hereby give permission to the Alfred State medical staff to examine and treat all medical problems/injuries while at Alfred State. In the event of time restraints, or that I cannot be reached, I hereby give permission for Health & Wellness staff to secure consultative care as needed. I understand that I have the right to revoke this consent at any time.

Student signature/Date AND Parent/guardian signature of a student under 18 years of age/Date