Student Health Forms

Required by New York State Law

Return By
AUGUST 1st for Fall Semester entry
JANUARY 15TH for Spring Semester entry

Concordia College New York
Attn: Student Health Center
171 White Plains Rd
Bronxville, NY 10708

IMPORTANT

NO STUDENT WILL BE PERMITTED TO ATTEND CLASS UNTIL FORMS ARE RETURNED

YOU MUST EITHER WAIVE OR ENROLL IN COLLEGE-OFFERED HEALTH INSURANCE ONLINE; INSTRUCTIONS INSIDE

Questions?

Contact the Student Health Services Office
Susan.Crane@concordia-ny.edu
914.337.9300 x2243

STUDENT ATHLETES – STOP!

This is not the Student Athlete form. Please contact the health center for the Student Athlete form.

IMPORTANT

NO STUDENT WILL BE PERMITTED TO ATTEND CLASS UNTIL FORMS ARE RETURNED

THIS FORM IS NOT VALID IF ANY INFORMATION IS MISSING

THIS FORM REQUIRES A HEALTH CARE PROVIDER'S SIGNATURE, STAMP AND LICENSE NUMBER

ALL SECTIONS ARE MANDATORY

Instructions

SECTION 1
Personal Health History and Physical Examination Form
Clinician's physical examination must be dated within the last year.

SECTION 2
Measles, Mumps, & Rubella Immunizations
New York State Vaccination Law 2165 and Concordia College require verification of vaccination or immunity for every registered Concordia student born after Jan. 1, 1957 documenting proof of immunity to Measles, Mumps, and Rubella.

> **MMR:** Two (2) doses are required for entry into Concordia College. The first dose must have been received on or after the 1st birthday.
>
> **OR**
>
> Immunity may be proven by a blood test for antibodies. Lab reports must be submitted and the provider must sign and stamp lab reports.
>
> **OR**
>
> **Measles (Rubeola):** Two (2) doses are required. The first dose must have been received on or after the 1st birthday.
> **Mumps:** One (1) dose is required and must have been received on or after the 1st birthday.
> **Rubella (German measles):** One (1) dose is required and must have been received on or after the 1st birthday. A previous history of having Rubella is *not* acceptable proof of immunity.

SECTION 3
Meningococcal Vaccine PLEASE READ CAREFULLY
As per New York State Public Health Law 2167, **all students residing in campus housing must have the vaccine**. If you are a commuting student and have not had the vaccine, you must sign a waiver stating you have read about the disease and decline the vaccine. It is highly recommended that all students have the meningitis vaccine.

CONCORDIA COLLEGE NEW YORK

SECTION 1-A: Personal Health History (To be completed by Student)

Name: ________________________________ **E-MAIL Address**:____________________

Concordia ID #__________________________ **Student Cell #**______________________

Home Address;____

Street City State Zip

Personal Information: Date of Birth______________ Age: _________Gender: Male__________Female__________

Student Type: First-Year:_______ Transfer:_________ **Housing Status:** Resident______Commuter_____

IT IS MANDATORY THAT YOU MAINTAIN HEALTH INSURANCE EVERY YEAR THAT YOU ATTEND CONCORDIA COLLEGE NY.

WHETHER YOU ARE ENROLLING OR DECLINING THE COLLEGE PLAN, YOU MUST DO SO ONLINE – PLEASE SEE LAST PAGE FOR INSTRUCTIONS

***INTERNATIONAL STUDENTS MUST ENROLL IN THE COLLEGE-OFFERED HEALTH INSURANCE PLAN**

PLEASE INCLUDE A COPY OF YOUR CURRENT INSURANCE CARD, FRONT AND BACK

Person to be notified in emergency: Name:__________________________Relationship:____________________

Address:____

Telephone: Home:_____________________Work:______________________

Personal History:

Please answer all questions. Comment on all positive answers in space allowed (see next page).

Have you had:	Yes	No
Scarlet Fever	☐	☐
Measles	☐	☐
German Measles	☐	☐
Mumps	☐	☐
Chicken Pox	☐	☐
Malaria	☐	☐
Nose/Throat Trouble	☐	☐
Eye Trouble	☐	☐
Recurrent Colds	☐	☐
Sinusitis	☐	☐
Hay Fever	☐	☐
Joint Disease or Injury:	☐	☐
"Trick" Knee, Shoulder	☐	☐
Back Problems	☐	☐
Diarrhea/Constipation	☐	☐
Gallbladder/Gallstones	☐	☐
Rupture, Hernia	☐	☐
Jaundice (Liver Disease)	☐	☐
Stomach/Intestine Trouble	☐	☐

	Yes	No
Thyroid Disease	☐	☐
Surgery:		
Appendectomy	☐	☐
Tonsillectomy	☐	☐
Hernia Repair	☐	☐
Other	☐	☐
Allergies to:		
Penicillin	☐	☐
Sulfonamides	☐	☐
Serum	☐	☐
Foods (list below)	☐	☐
Other	☐	☐
Females Only:		
Irregular Periods	☐	☐
Severe Cramps	☐	☐
Excessive Flow	☐	☐
Other	☐	☐

Continued ➡

Name: ____

	Yes	No		Yes	No
Frequent Anxiety	☐	☐	Chronic Cough	☐	☐
Frequent Depression	☐	☐	Shortness of Breath	☐	☐
Nervousness	☐	☐	Heart Murmur	☐	☐
Head injury	☐	☐	Heart Palpitations	☐	☐
with Unconsciousness	☐	☐	Rheumatic Fever	☐	☐
Recurrent Headaches	☐	☐	Pain/Pressure in Chest	☐	☐
Gum/Tooth Problems	☐	☐	High or Low Blood Pressure	☐	☐
Acne	☐	☐	Diabetes	☐	☐
Epileptic Seizures	☐	☐	Frequent Urination	☐	☐
Tumor, Cancer, Cyst	☐	☐	Sexually Transmitted Disease	☐	☐
Dizziness, Fainting	☐	☐	(STD)	☐	☐
Weakness/Paralysis	☐	☐	Recent Weight Gain or Loss	☐	☐
Tuberculosis	☐	☐			
Asthma	☐	☐			

A. Has your physical activity been restricted during the past five years? Yes No (If yes, explain below.)
B. Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem? Yes No (If yes, give details below.)
C. Have you had any illness or injury or been hospitalized other than already noted? Yes No (If yes, give details below.)
D. Have you consulted or been treated by clinics, physicians, or other practitioners within the past five years? (other than routine checkups?) Yes No
E. Do you smoke, dip, or chew tobacco? Yes No
F. Do you take any medication at present? Yes No (If Yes, Please list below)
G. Do you drink alcohol? Yes No If Yes, what type and how often? ______________________
H. Do you use recreational drugs? Yes No (If Yes, Please list below)

Comments:

____
____
____
____
____

Family History

Among your relatives is there any history or present illness from the following: If yes, what relative?

	Yes	No	Relative		Yes	No	Relative
Cancer Diabetes	☐	☐	________	Convulsions	☐	☐	________
Allergy	☐	☐	________	Arthritis	☐	☐	________
Tuberculosis	☐	☐	________	Stomach disease	☐	☐	________
Kidney Disease	☐	☐	________	Nervous difficulties	☐	☐	________
Heart disease,	☐	☐	________	Any other disease	☐	☐	________
high blood pressure or stroke			________				

Medical and Surgical Authorization: In case of illness and/or injury, authority and consent is given to Concordia College for examination and treatment of named student either at the Health Center or Wellness Center, Concordia College, or by outside physicians and medical facilities as are available. Consent is further given for admission to a hospital for necessary medical or surgical treatments as ordered by a physician. It is agreed that all medical and/or hospital expenses incurred beyond those covered by any applicable student insurance policy will be paid directly and promptly by the undersigned student and parents or guardians and the College will not be held responsible.

Date ____________ Student's Signature ____ Age __________

Date ____________ Parent or Guardian's Signature ____

(If under age 18 and unmarried, parent or guardian must also sign.)

CONCORDIA COLLEGE NEW YORK

Section 1-B. PHYSICAL EXAMINATION FORM (To be completed by a Health Care Provider)

Student's Name:________________________________ **Concordia ID#: C**_____________

Gender (circle): M F **Date of Birth:**__________

Date of Exam:________________ (to be completed only by MD, DO, NP or PA)

Height:___________**Weight:**____________**BMI:**_________**BP:**____________**Pulse:**__________
Vision: R 20/ L 20/

Current Medications:____

Allergies to Medications:____

Type of reaction:____________

Other Allergies:____

Type of reaction:____________

SYSTEM	NORMAL	DESCRIBE ABNORMALITY
Skin		
HEENT		
Lungs/Chest		
Breasts		
Heart/Vascular System		
Abdomen (rectal if indicated)		
Genito-urinary		
Pelvic (if indicated)		
Musculoskeletal		
Neurological		
Psychological		
Other:		

Current & Chronic Problems

1.______________________________2.____________________________3.______________________________

IF THE STUDENT IS UNDER CARE FOR A CHRONIC OR SERIOUS ILLNESS, PLEASE DESCRIBE BELOW AND ATTACH ADDITIONAL CLINICAL REPORTS TO ASSIST US IN PROVIDING CONTINUITY OF CARE.

____

____

____

____

RECOMMENDATIONS FOR PHYSICAL ACTIVITY: Unlimited Limited

(specify):____

Signature: ____ **Stamp:** __________________________________
(Physician, DO, NP, PA)

ADDRESS:___________________________________**PHONE:**________________________________

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COPIES OF EMR IMMUNIZATION REPORTS WILL BE ACCEPTED IF SIGNED AND STAMPED BY THE PROVIDER

Varicella (chicken pox) Dose #1 ____________Dose #2_________

Recommended for good health (not mandatory)

Tdap (Tetanua-Diptheria-Pertussis): Immunization booster within last 10 years

Date: _____/_____/_____

Hepatitis B Vaccine: Dose #1 _____/_____/_____ Dose #2 _____/_____/_____

Dose #3 _____/_____/_____

Tuberculin Skin Test (PPD Only) To have been done within six (6) months prior to coming to Concordia

Date Planted:_________________________________

Date Read:___________________________________

Results in mm:________________________________

(if chest x-ray was done, please attach a copy of the report)

CONCORDIA COLLEGE NEW YORK

SEC. 2 *MANDATORY* MEASLES, MUMPS, RUBELLA VACCINE REQUIREMENTS OR ATTACH IMMUNIZATION RECORD (To be completed by Health Care Provider)

Student's Name: ____________________________ Concordia ID# C ____________________________
Phone Number: (___) ____________________________ Date of Birth: ____________________________
E-Mail: ____________________________

Student Type: First-Year Sophomore Junior Senior Transfer

Health Care Provider (please print)____________________________
Address:____________________________
Phone: (_____)____________________ **Fax:(_____)**____________________
Provider's Signature:____________________________

REQUIRED IMMUNIZATIONS for ALL students born after 1/01/57

Section A. MMR (Measles, Mumps, Rubella; was not available in the U.S. before 1/1/72)

_____ 1st MMR Dose (Administered after 1st birthday AND after 1/1/1972) _____/_____/_____

AND

______ 2nd MMR Dose (Administered after 15 months of age and at least 28 days after 1st dose) _____/_____/_____

Section B1. Measles

Month/Day/Year

_____ 1st Live Virus Dose (Administered after 1st birthday & 1/1/69) _____/_____/_____

AND

_____ 2nd Live Virus Dose (Administered after 15 months of age and at least 28 days after 1st dose) _____ / _____ / _____

OR

_____History of Illness (documented with statement by diagnosing provider)

OR _____Immunity (Proven by Serologic Testing – attach labs)

Section B2. Mumps

Month/Day/Year

_____1st Live Virus Dose (Administered after 1st birthday & 1/1/69) _____/_____/_____

OR

_____Immunity (Proven by Serologic Testing -attach labs)

Section B3. Rubella (German Measles)

Month/Day/Year

_____ Live Virus Dose (Administered after 1st birthday & 1/1/69) _____ /____ / ____

OR

_____Immunity (Proven by Serologic Testing-attach labs)

Note: History of Illness is NOT acceptable

continued ➡

Sec. 3. Meningococcal Meningitis Vaccination Response Form

(To be completed by Health Care Provider)

A. Meningococcal Meningitis Vaccine (Menactra™/Menomune™): Please consider this vaccine. Students wishing to decline this vaccine must read the information in the box below. **Signing the waiver indicates that you understand the possible risk involved in not receiving this immunization.** If you are under the age of 18, a parent or legal guardian must sign this waiver for you.

Disclosure Statement-Meningococcal Meningitis: College students, especially first-year students living in residence halls, are at a slightly increased risk for contacting meningococcal disease. The bacterial form of this disease can lead to serious complications such as swelling of the brain, coma, and even death within a short period of time. A vaccine is currently available that will decrease, but not completely eliminate, a person's risk of acquiring meningococcal meningitis. This element of uncertainty remains because there are five (5) different serotypes (A, B, C, Y, & W-135) and the current vaccine does not offer any protection from serotype B. The vaccine, Menactra™/Menomune™, probably protects for 3-5 years, and is extremely safe for use. Menactra™ vaccine is available at the Concordia Student Health Center for a cost of $125. For more specific information about meningococcal meningitis and college student risks, please visit the NYS DOH website at: www.health.state.ny.us/nysdoh/immun/meningococcal/index.htm

Mandatory -Read Carefully: As per New York State Public Health Law 2167, you must either have the vaccine or sign a waiver stating you have read about the disease and decline the vaccine.

(circle one:) Menomune / Menactra

A. Meningococcal Meningitis Vaccine (Menomune™ or Menactra™) given within the past 10 years:

Date: ________/__________/_________ (Month / Day / Year) **Date:** ________/__________/________ (Month / Day / Year)

NOTE: IT IS STRONGLY RECOMMENDED THAT A 2ND DOSE OF MENINGITIS VACCINE BE ADMINISTERED TO ALL ADOLESCENTS WHO RECEIVED THE FIRST DOSE PRIOR TO AGE 16. PLEASE ALSO ASK YOUR PROVIDER ABOUT THE *MENINGITIS B* VACCINE.

An official stamp from a doctor's office, clinic, or health department AND an authorized signature must be provided below.

____ ________________________

Clinician Signature **Date**

OR

____

Name/License#/Office Stamp

Read the information provided above and sign the waiver below.

_____ 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 my child/I will not obtain immunization against meningococcal meningitis disease.

Signature of Student and/or Parent/Guardian (If student is under 18)

_________________________________Date:___________

CONCORDIA
COLLEGE NEW YORK

WAIVE OR ENROLL IN COLLEGE-OFFERED HEALTH INSURANCE

Your bill reflects a charge for the College-offered health insurance. If you are a domestic student and covered by your family's plan or another plan, you may decline the College-offered Health Insurance online at the website below.

IMPORTANT

INTERNATIONAL STUDENTS ARE REQUIRED TO ENROLL IN THE COLLEGE-OFFERED HEALTH INSURANCE

IF YOU HAVE OUT-OF-STATE MEDICAID, PLEASE CONTACT THE STUDENT HEALTH CENTER

www.gallagherstudent.com/concordiany

1. On the top right corner of the screen, click 'Student Login' and log in.
2. On the left toolbar, click 'Student Waive/Enroll'.
3. Choose to waive or enroll. Follow the instructions to complete the form.
4. Print or write down your reference number.
5. If you choose to enroll, you will receive an enrollment packet with instructions for enrolling. The charge on your bill does not indicate enrollment; please follow the instructions in your enrollment packet.

PLEASE ATTACH A COPY OF YOUR VALID HEALTH INSURANCE CARD, FRONT AND BACK