SUNY ERIE
State University of New York

Confidential Student Health Form *(Student completes front side)*

College Entry Date: _____/FA_____/SP
Official Use only: r_____ c_____

PART I PERSONAL INFORMATION

Name_____
Last First Middle

Address_____
Street City State Zip

Phone (____) _____ ID Number or Social Security _____
Birth date _____ /_____/_____ Are you a US Veteran with a DD214. Yes (circle one) No
Emergency Contact_____
Name Relationship Phone

Name of High School _____ Year you graduated or last attended_____
Name of any previous college(s) _____
Family Physician_____ Phone number (_____) _____

PART II
MEDICAL PROBLEMS (If none check box ☐**)** **Medications or treatment for medical problem**:

1. _____ _____
2. _____ _____
3. _____ _____

List operations/severe injuries if any: _____
Do you require any medication for a bee sting? _____If yes, what? _____
List any drug, food, or contact allergies and medication if required _____
OPTIONAL: Do you have physical, behavioral or academic disorders? _____
If yes, are you aware of the Student Access Center? _____
I certify that the above information is true to the best of my knowledge:
Student Signature: _____Date: _____

PARENTAL CONSENT FOR MEDICAL TREATMENT OF MINOR

(New York State Law Requires Parental Consent for the Medical Treatment of a person under 18 years of age)
I HEREBY GIVE CONSENT FOR HEALTH SERVICES AND ITS DESIGNEES TO PROVIDE MEDICAL TREATMENT TO MY SON/DAUGHTER
Name of Student_____ Student ID#_____
(Please print)
Parent/Guardian Signature_____ Date Signed_____

PART III MENINGOCOCCAL MENINGITIS WAIVER

This part is required for those who choose to decline this highly recommended but optional vaccination.

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 (*or my child*) **will not** obtain immunization against Meningococcal Meningitis at this time. I reserve the right to consider receiving the immunization in the future for myself (or my child).

Student signature_____Date_____
Parent signature_____Date_____
(Parent signature required only if student is under the age of 18)
****IF YOU WERE BORN AFTER 1956, THE OTHER SIDE OF THIS FORM IS REQUIRED****

Name: _____ Date of Birth_____/_____/_____
Mo Day Year

IMMUNIZATION REQUIREMENTS

PLEASE ATTACH AN OFFICIAL COPY OF YOUR IMMUNIZATION RECORD or IF NO RECORD IS AVAILABLE, A HEALTH CARE PROVIDER WILL NEED TO COMPLETE AND SIGN THIS SECTION. New York State requires college students enrolled for six credit hours or more to submit proof of immunity to Measles, Mumps, and Rubella. The law applies to students born on or after January 1, 1957. Meningococcal meningitis vaccine is highly recommended but optional –the student must sign the waiver on the first page if declining the vaccination. Failure to comply will result in removal from classes in accordance with NYS Public Health Laws 2165 and 2167.

REQUIRED: Measles (Rubeola) Immunity

Must have one of the following:

1. **TWO** Dates of Measles or MMR Immunization: (1) _____/_____/____ (2) ____/____/____

Measles vaccine acceptable if given 1968 or later. MMR vaccine acceptable if given 1972 or later.

Vaccinations must be on or after first birthday and a minimum of 30 days apart. Please specify type of vaccine. ***or***

2. Date of Measles Titer and Result

Date: _____/_____/_____ ***Please circle result****:* *Immune* *Not Immune*

REQUIRED: Mumps Immunity

Must have one of the following:

1. **ONE** Date of Mumps or MMR Immunization: (1) _____/_____/_____ (2) ____/____/____.

Must be on or after first birthday. Vaccine not acceptable if given before 1969. ***or***

2. Date of Mumps Titer and Result

Date: _____/_____/_____ **Please circle result**: Immune Not Immune

REQUIRED: German measles (Rubella) Immunity

Must have one of the following:

1. **ONE** Date of Rubella or MMR Immunization: (1) _____/_____/_____ (2) ____/____/____.

Must be on or after first birthday. Vaccine not acceptable if given before 1969. ***or***

2. Date of Rubella Titer and Result

Date: _____/_____/_____ **Please circle result**: Immune Not Immune

Recommended (Optional): Meningococcal Meningitis vaccination (within last 5 years)

Please specify vaccine type: Menomune Menactra Menveo mcv4

1. _____/_____/_____ **2. _____/_____/_____**

The health care provider below has validated the above immunization record.

_____ _____
HEALTH CARE PROVIDER SIGNATURE *HEALTH CARE PROVIDER NAME PRINTED OR STAMPED*

_____
STREET *CITY* *STATE* *ZIP*

( )

_____ _____
TELEPHONE NUMBER *DATE*

Please return this completed form to the ECC Health Services Office at the campus where your program of study is located:

CITY CAMPUS
121 Ellicott St., Rm. 228
Buffalo, NY 14203
Telephone (716) 851-1199
Fax (716) 270-2854

NORTH CAMPUS
6205 Main St., Rm. S-152
Williamsville, NY 14221
Telephone (716) 851-1499
Fax (716) 851-1498

SOUTH CAMPUS
4041 Southwestern Blvd., Rm. 5109
Orchard Park, NY 14127
Telephone (716) 851-1699
Fax (716) 270-2833

******It is very important to keep a copy of the completed form for your PERMANENT RECORD******

Revised 03/17/21