



Student Health Services
102 Carroll Hall
4245 East Avenue
Rochester, NY 14618-3790
(585) 389-2500
Fax (585) 389-2503
www.naz.edu/dept/health services

**INSTRUCTION COVER SHEET
for
STUDENT HEALTH SERVICES IMMUNIZATION AND HEALTH FORMS**

For Fall admittance, this form is due by August 1st

For Spring admittance, this form is due by January 5th

Students admitted after the deadline should return the complete form without delay.

Dear Student:

Attached are the Nazareth College Student Health Services Immunization Record and Health History Forms. These forms must be completed in their entirety. All information must be legible (please print) and in English. Failure to comply with written directions may jeopardize your enrollment for the semester. If you have any questions, please call Student Health Services at (585) 389-2500.

Please read the Instruction Cover Sheet carefully

- Page 1** Is to be filled out by the student
Page 2 Is to be filled out by the student and signed
Page 3 Must be completed by your health care provider, signed and stamped
A physical examination is not required

Please return the completed forms to Student Health Services in the envelope provided. Keep a copy of your completed forms pages 1 – 3.

Meningococcal Meningitis Information (pursuant to NYS Public Health Law 2167)

Meningitis is an infection of the fluid of a person's spinal cord and the fluid that surrounds the brain. Viral meningitis is generally less severe and resolves without specific treatment, while bacterial meningitis can be quite severe and may result in brain damage, hearing loss, disability or rarely, death.

What are the signs and symptoms of meningitis? High fever, headache, and stiff neck are common symptoms of meningitis. These symptoms can develop over several hours, or may take 1 to 2 days. Other symptoms may include nausea, vomiting, discomfort looking into bright lights, confusion, and sleepiness. Bacterial meningitis can be treated with a number of effective antibiotics.

Meningitis is transmitted through air via droplets or respiratory secretions and direct contact (shared glassware or cigarettes, kissing) with an infected person. Only people in close contact need to be considered for preventative treatment.

Presently there is a vaccine that will protect against the most common strains of the disease. The vaccine is safe and adverse reactions are mild and infrequent. The vaccine is recommended for all children at their routine preadolescent visit, college freshmen living in dormitories, U.S. military recruits, anyone whose spleen has been removed; those traveling to the countries which have an outbreak of meningococcal disease, and those who might have been exposed to meningitis during an outbreak.

If you wish to receive the vaccine, please contact your health care provider. For more information go to www.cdc.gov/ncidod/DBMD/diseaseinfo/meningococcal_g.htm



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**NAZARETH COLLEGE STUDENT HEALTH SERVICES IMMUNIZATION RECORD
 TO BE COMPLETED BY HEALTH CARE PROVIDER**

Name: _____ Date of Birth: _____

**MEASLES MUMPS AND RUBELLA DOCUMENTATION IS REQUIRED OF ALL STUDENTS
 ENROLLED FOR 6 OR MORE CREDIT HOURS**

For all students born on or after January 1, 1957, NYS Public Health Law 2165 mandates that you provide signed documentation of proof of immunity against Measles, Mumps and Rubella. **Students who do not comply with this mandate will be deregistered the first week of the semester.**

Proof consists of the following:

2 MMR Injections

MMR #1: On or after first birthday & on or after 1/1/68

MMR #2: At least one (1) month after the first dose

Month/Day/Year

____/____/____

____/____/____

OR

Verification of Immunity to Measles, Mumps and Rubella Individually

Measles (Rubeola)

Disease confirmed by office record

Lab report of titer (Must submit copy)

____/____/____

____/____/____

____/____/____

OR

Dose 1: Immunized on or after first birthday &

Dose 2: Immunized at least one (1) month after first dose

____/____/____

____/____/____

Mumps

Disease confirmed by office record **or**

Lab report of titer (Must submit copy) **or**

Immunized on or after first birthday

____/____/____

____/____/____

____/____/____

Rubella (German Measles)

Lab Report of titer (must submit) **or**

Immunized on or after first birthday

____/____/____

____/____/____

____/____/____

ADDITIONAL RECOMMENDED IMMUNIZATIONS

Last Tetanus Booster

Meningococcal Vaccine

Hepatitis B Series

#1 ____/____/____

#2 ____/____/____

3# ____/____/____

____/____/____

____/____/____

 Health Care Provider Name

 Signature Required Date

Phone: () _____ Fax: () _____

Provider Stamp

**NAZARETH COLLEGE STUDENT HEALTH SERVICES
MEDICAL HISTORY**

To be completed by student and signed at bottom

Name: _____ Date of Birth: _____

Height _____ in. Weight _____ lbs.

All medical/physical and mental health conditions:

All current medications (including over the counter, vitamins, herbs and supplements):

Previous hospitalizations (dates and reasons):

Medication allergies and reactions:

Check any conditions listed below that pertain to you and give the date of event or onset of condition

	Date		Date
<input type="checkbox"/> Acne	_____	<input type="checkbox"/> GERD/Indigestion	_____
<input type="checkbox"/> Allergies/Hay Fever	_____	<input type="checkbox"/> Headaches (<i>Type</i> _____)	_____
<input type="checkbox"/> Anemia	_____	<input type="checkbox"/> Hepatitis (<i>Type</i> _____)	_____
<input type="checkbox"/> Anxiety	_____	<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Irritable Bowel Syndrome	_____
<input type="checkbox"/> Attention Deficit Disorder	_____	<input type="checkbox"/> Mononucleosis	_____
<input type="checkbox"/> Binge Eating/Purging	_____	<input type="checkbox"/> Restricted Eating	_____
<input type="checkbox"/> Cancer (<i>Type</i> _____)	_____	<input type="checkbox"/> Seizure Disorder (<i>Type</i> _____)	_____
<input type="checkbox"/> Chicken Pox	_____	<input type="checkbox"/> Self harming behavior i.e. cutting	_____
<input type="checkbox"/> Depression	_____	<input type="checkbox"/> Sleep Disturbance	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Thyroid Disorder	_____
<input type="checkbox"/> Drug or Alcohol Dependency	_____	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Eczema	_____	<input type="checkbox"/> Urinary Tract Infections	_____

FEMALES

How many periods did you have in the last 12 months? _____

Have you had an abnormal Pap smear? Yes/No: If Yes: Treatment _____

I certify that my responses are complete and true to the best of my knowledge.

Signature

Date