



This form includes your:

1. Health History and Assessment; 2. Immunization Requirements;
3. Meningococcal Meningitis Vaccination Response Form

Health History and Assessment

All Adelphi students must have a completed Health History and Assessment form on file in the Health Services Center prior to registration. If you have any questions, please contact the Center at (516) 877-6000. Please complete all four pages of this form, and return in the enclosed Business Reply envelope to Health Services. All medical information will be maintained in confidence pursuant to the Family Education Rights and Privacy Act of 1974.

PART I (To be completed by student) PLEASE PRINT

Last name _____ First name _____ Middle name _____

Address _____
Street Apartment City State ZIP

Adelphi Student ID/or SS# _____ Birthdate _____
(preferred)

CONTACT INFORMATION

Home Phone () _____ Cell Phone () _____ Email _____

EMERGENCY CONTACT

Name _____

Relationship _____ Home () _____ Cell/Work () _____

CONSENT FOR MEDICAL/MENTAL HEALTH EVALUATION & TREATMENT OF MINORS – STUDENTS UNDER 18 YEARS OLD

To provide medical or mental health evaluation or treatment to students under the age of 18, parental permission is necessary by law. I hereby grant permission for: (check appropriate statements below and sign)

- Medical evaluation, treatment, and hospitalization in case of accident or illness for my minor child/legal ward. I also give permission for the release of information concerning his/her medical condition to other responsible University officials when necessary or outside agency for treatment on an as-needed basis.
- Mental health services for my minor child/legal ward.

Signature of Parent/Guardian (if student is a minor) _____ Date _____

Have you had any serious accidents, broken bones, or surgical operations? Yes No

If yes, please specify and provide dates: _____

Check any illnesses you have had and indicate month and year, if known (consult your physician if necessary).

- | | | | | | |
|---|---------|---|---------|---|---------|
| <input type="checkbox"/> Frequent headaches | ___/___ | <input type="checkbox"/> Pneumonia/pleurisy | ___/___ | <input type="checkbox"/> Diabetes | ___/___ |
| <input type="checkbox"/> Epilepsy/convulsions | ___/___ | <input type="checkbox"/> Tuberculosis | ___/___ | <input type="checkbox"/> Hypoglycemia | ___/___ |
| <input type="checkbox"/> Thyroid dysfunction | ___/___ | <input type="checkbox"/> Infectious mononucleosis | ___/___ | <input type="checkbox"/> Kidney/urinary infection | ___/___ |
| <input type="checkbox"/> Cancer | ___/___ | <input type="checkbox"/> Allergy | ___/___ | <input type="checkbox"/> Hernia | ___/___ |
| <input type="checkbox"/> Asthma | ___/___ | <input type="checkbox"/> Drug sensitivity | ___/___ | <input type="checkbox"/> Heart disease | ___/___ |
| <input type="checkbox"/> Anemia | ___/___ | <input type="checkbox"/> Stomach/bowel difficulty | ___/___ | <input type="checkbox"/> Scarlet fever | ___/___ |
| <input type="checkbox"/> High blood pressure | ___/___ | <input type="checkbox"/> Hepatitis | ___/___ | <input type="checkbox"/> Skin disorders | ___/___ |
| <input type="checkbox"/> Low blood pressure | ___/___ | <input type="checkbox"/> Eye/ear/nose/throat infections | ___/___ | <input type="checkbox"/> Bone/joint disease | ___/___ |

Rheumatic fever ___/___ Bleeding disorders ___/___ Menstrual disorders ___/___

Do you have any physical (temporary or permanent) or emotional problems of which the University should be aware in order to assist you in the achievement of your educational goals? Yes No

If yes, please describe: _____

Are there any prescribed medications that you require on a regular basis? Yes No

If yes, please indicate type, dosage, and frequency: _____

Are you allergic to any medications or food? (Please list) _____

FAMILY HISTORY

Diabetes Yes No Cancer Yes No Allergy/Asthma Yes No

Tuberculosis Yes No Heart disease Yes No Anemia Yes No

Epilepsy Yes No Hypertension Yes No Blood disease Yes No

PART II (To be completed and signed by healthcare provider)

HEALTHCARE PROVIDER'S EXAMINATION

Height _____ Nose _____ Thyroid _____

Weight _____ Mouth _____ Chest _____

Blood pressure _____ Tongue _____ Heart _____

Vision R _____ L _____ Teeth _____ Abdomen _____

Vision corrected R _____ L _____ Throat _____ Skin _____

Eyes _____ Pulse _____ Varicosities _____

Ears _____ Respirations _____ Reflexes _____

Mantoux (required one year prior to entrance) Date _____ Result _____

If the mantoux is positive, a chest X-ray is required and the report must be attached to this completed form.

Routine urinalysis Date _____ Result _____

Previous medical history _____

In your judgment, is there any reason why physical education and/or athletic activities would be contraindicated? Yes No

If yes, please explain. _____

RECOMMENDED IMMUNIZATIONS

If there are valid reasons for noncompliance with state regulations, written proof on physician's stationery is required and must be attached to this completed form.

Chicken Pox _____/_____/_____

Whooping Cough _____/_____/_____

Polio _____/_____/_____

Tetanus Toxoid (within 10 yrs.) _____/_____/_____

Hepatitis B Series _____/_____/_____

SEE NEXT PAGE FOR NEW YORK STATE MANDATED IMMUNIZATIONS →

I have this day given _____ a careful examination and have found this person in _____ health.

Are you the family healthcare provider? Yes No How long have you known the applicant? _____

Health Care Providers Name _____ Signature _____

Address _____ City _____ State _____ ZIP _____

Registration Number _____ Date of Examination _____

Health Care Provider Stamp required

Immunization Requirements

New York State law requires certain immunizations for college and post-secondary students. In order to attend classes, students must provide proof of immunity against measles, mumps, and rubella. **All students must comply with this law, unless medically or religiously contraindicated.** Students born prior to January 1, 1957, must submit proof of age to be exempt from these requirements. This information must be received prior to registration.

In order to comply with the New York State Immunization Law, you must fulfill one of the three numbered requirements.

1. Doses of Live Virus Vaccine

- a. Measles: two doses at least 28 days apart, which must be given no more than four days prior to the first birthday and after 1967
Mumps: one dose after 1968
Rubella: one dose after 1968

or

- b. MMR: two doses at least 28 days apart, which must be given no more than four days prior to the first birthday and after 1971

or

- c. MMR: one dose after the first birthday and after 1971
Measles: one dose after the first birthday and after 1967

2. Documentation of Medically-Diagnosed Disease

This applies to measles and mumps only, not to rubella. Only serologic evidence of immunity (titer) or proof of vaccinations are acceptable.

3. Serologic Evidence of Immunity for Each Disease

Laboratory reports verifying immunity to measles, mumps, and rubella are required.

NEW YORK STATE MANDATED IMMUNIZATIONS

Student/Patient Immunization Information (Must be written in English)

Last Name	First Name	Birthdate			
Adelphi Student ID. Number					
Social Security Number		Measles	Mumps	Rubella	MMR
*Serologic evidence requires a copy of the laboratory report.	First Dose				
	Second Dose				
	Physician's report of disease				
	Serologic evidence*				

Healthcare Provider: Please sign and stamp. (Official Stamp Required)

Signature

Date



Meningococcal Meningitis Vaccination Response Form

New York State Public Health Law requires that all college and university students enrolled for at least six semester hours or the equivalent per semester, complete and return the following form to the Adelphi University Health Services Center.

Check one and sign below.

I have (for students under the age of 18: My child has):

- Had the meningococcal meningitis immunization within the past five years.

Date received: _____ Healthcare Provider Stamp Required: _____

- Read, or have had explained to me, the information regarding meningococcal meningitis disease. I (My child) will obtain immunization against meningococcal meningitis within 30 days from my private healthcare provider or the Adelphi University physicians.

- 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.

Signature of Student (if 18 or older)/Parent/Guardian (if student is a minor) Date

STUDENT INFORMATION

Last Name _____ First Name _____ Middle Name _____

Address _____
Street Apartment City State ZIP

Adelphi Student ID or SS# _____ Birthdate _____

CONTACT INFORMATION

Home Phone () _____ Cell Phone () _____ Email _____

This form must be returned to the Adelphi University Health Services Center, Waldo Hall, One South Avenue, P.O. Box 701, Garden City, NY 11530-0701 or faxed to: (516) 877-6008 within 30 days of the beginning of class or, by New York State law, you will not be permitted to attend class or live on campus.

Official Use Only

M	M	R	M	