All Students (Matriculated and Nonmatriculated) Failure to meet immunization requirements as outlined will result in ineligibility to advance-register for the following semester and any subsequent semesters.

- Compliance with Public Health Law 2165 is a condition of enrollment at the college. All students born on or after January 1, 1957, must include documented proof of immunity to measles, mumps, and rubella as required by New York State Public Health Law 2165. This is mandatory and is a condition of subsequent registration.

- Compliance with NYS Public Health Law 2167 regarding meningococcal meningitis vaccine is a condition of enrollment at this college. All students enrolled must complete the meningococcal meningitis vaccination response form found on page 2 of this health report.

- If you encounter difficulties meeting health requirements, please notify the Health Center.

It is recommended by the college that each student be covered for medical/surgical care by some form of insurance.

False, inaccurate, or incomplete information submitted on this form places the student at risk. The consequences for such action are the responsibility of the student or, in the case of a minor, his/her parents, or guardian.

I have read and understand the above __________________________________________ Signature of Student

I have read and understand the above __________________________________________ Signature of Parent or Guardian of Student under 18

Transfer Students

- You may submit a health form from another institution as long as (1) it contains all the information required on the Oneonta form, and (2) you have not been out of school for more than one year. The Health Center is willing to review such forms at your request.

Readmit Students

- If you have previously submitted a health form, please call the Health Center to check on your current requirement in this regard.

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**PERSONAL INFORMATION TO BE COMPLETED BY THE STUDENT**

Name (please print) ____________________________ Last ___ First ___ Middle ___

Home Address ____________________________ Street ___ City ___ State ___ Zip ___

Date of Birth ____________________________ Social Security No. _________ / _________ / _________

Parent or Guardian ____________________________ Last ___ First ___ Middle ___

Home Telephone ( _______ ) ____________________________ Business Telephone ( _______ )

Address ____________________________ Street ___ City ___ State ___ Zip ___

Family Physician (print), ____________________________ Last ___ First ___ Middle ___

Address ____________________________ Street ___ City ___ State ___ Zip ___

<table>
<thead>
<tr>
<th>#1 Local Address</th>
<th>Date</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
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<th>Zip</th>
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Name

THIS PAGE IS MANDATORY FOR ALL STUDENTS

Immunization Requirements (must be completed by Primary Care Provider. See front page for information)

<table>
<thead>
<tr>
<th></th>
<th>1st dose</th>
<th>2nd dose</th>
<th>3rd dose</th>
<th>4th dose</th>
<th>5th dose</th>
<th>last booster</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Tetanus toxoid and diphtheria (suggested)</td>
<td></td>
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<tr>
<td>Three or more doses required. Most recent dose must be within 10 years prior to entry</td>
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<td>2. Polio Vaccine (suggested)</td>
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<tr>
<td>Minimum of three doses for all students 18 and under. For those 19 and over, record previous doses but no additional doses should be given</td>
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<tr>
<td>3. Measles (Rubeola) (required for all students)</td>
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<td>4. Mumps (required for all students)</td>
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<td></td>
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<tr>
<td>5. Rubella (required for all students)</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. MMR (required for all students) (measles, mumps, rubella vaccine combined)</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
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<tr>
<td>7. Varicella Vaccine (suggested)</td>
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<tr>
<td>8. Hepatitis B immunization (suggested)</td>
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</tbody>
</table>

MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE FORM
REQUIRED FOR ALL STUDENTS

New York State Public Health Law 2167 requires that all college and university students enrolled must complete and return the following form to Student Health Center, SUNY Oneonta, Ravine Parkway, Oneonta, NY 13820.

Please note that according to NYS Public Health Law, no institution shall permit any student to attend the institution in excess of 30 days without complying with this law. The 30 day period may be extended to 60 days if a student can show a good faith effort to comply.

Check one box and sign below.

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

☐ had the meningococcal meningitis immunization (Menomune) within the past 10 years.

Date Received: Month:    Day:    Year:    

☐ 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 the immunization against meningococcal meningitis disease.

Signed ___________________________            Date _______________

Student or Parent/Guardian if student is a minor

Note: for those who want to receive the vaccine, check with your primary care provider or it is available at the Student Health Center, SUNY Oneonta for a fee. Please call (607) 436-3573 to set up an appointment.

Examiner Signature ___________________________
TO BE COMPLETED BY STUDENT AND FAMILY

Name ______________________________ Date of Birth ______________________________

FAMILY HISTORY: (List familial diseases: diabetes, epilepsy, tuberculosis, hypertension, mental illnesses, other)

PERSONAL HISTORY

Check the following diseases or conditions the student has had:

- Chicken Pox
- Measles
- Rubella (German Measles)
- Mumps
- Scarlet Fever
- Whooping Cough
- Diphtheria
- Frequent Colds
- Frequent Sore Throats
- Otitis Media (Ear Infections)
  - Residual impairment of hearing
- Sinusitis
- Tonsillitis
- Bronchitis
- Pneumonia
- Congenital or Other Heart Problems
- Rheumatic Fever-residual damage
- Cholera
- Rheumatoid Arthritis
- Epilepsy
- Psychiatric Disease
- Emotional Disorder
- Speech Impairment
- Tuberculosis or TB Contact
- Diabetes
- Anemia
- Malaria
- Infectious Mononucleosis
- Jaundice or Hepatitis
- Poliomyelitis-residual effects
- Kidney Disease
- Orthopedic problems
- Chronic intestinal problems
- Malignancy
- Asthma
- Eczema
- Hay Fever
- Hives
- Bulimia
- Anorexia
- Other

Allergies to:
- Drugs: __________________________
- Foods: __________________________
- Other: __________________________

Do you receive allergy injections: __________________________

Any past/present serious injuries, surgeries, illnesses or hospitalizations: __________________________

Do you smoke: __________________________

Any history of substance abuse: __________________________

Have you ever had psychotherapy or counseling: Yes[ ] No[ ]

List all medications you are currently taking, prescription and nonprescription: __________________________

To be completed by Health Care Provider

Physical Examination must be obtained within one year of admission. Recommended for all students - MANDATORY FOR ALL ATHLETES.

Blood Pressure: __________________________

Pulse: __________________________

Height: __________________________

Weight: __________________________

Vision: Far: __________________________

Right 20/ __________________________

Corr. to 20/ __________________________

Far: __________________________

Left 20/ __________________________

Corr. to 20/ __________________________

Check each item in proper column. Write N. E. if not evaluated

<table>
<thead>
<tr>
<th></th>
<th>Normal</th>
<th>Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Head, neck, face, and scalp</td>
<td>11. Abdomen and viscera (include hernia)</td>
</tr>
<tr>
<td>2</td>
<td>Nose and sinuses</td>
<td>12. Ano-rectal (pilonidal)</td>
</tr>
<tr>
<td>3</td>
<td>Mouth and throat</td>
<td>13. Endocrine system</td>
</tr>
<tr>
<td>4</td>
<td>Teeth and gingiva</td>
<td>14. G-U system</td>
</tr>
<tr>
<td>5</td>
<td>Ears</td>
<td>15. Upper extremities (strength, range of motion)</td>
</tr>
<tr>
<td>6</td>
<td>Eyes</td>
<td>16. Lower extremities (strength, range, motion)</td>
</tr>
<tr>
<td>7</td>
<td>Lungs</td>
<td>17. Spine</td>
</tr>
<tr>
<td>8</td>
<td>Breast Exam</td>
<td>18. Skin and lymphatics</td>
</tr>
<tr>
<td>9</td>
<td>Heart (include estimate of cardiac function)</td>
<td>19. Neurologic</td>
</tr>
<tr>
<td>10</td>
<td>Vascular system (varicoseles, etc.)</td>
<td>20. Psychiatric</td>
</tr>
</tbody>
</table>

Please provide a brief explanation of all items checked "abnormal."

(may attach extra sheets if necessary.)

Lab data: Hgb Value/Date __________________________ Urinalysis: __________________________

Tuberculin Mantoux Test only _____ TU _____ Dosage __________________________

Date Given: __________________________ Date Read: __________________________

(must be read within 48–72 hours)

Reaction: __________________________ MM: __________________________

Positive reactors to any TB test must submit results of chest X-ray: __________________________ date: __________________________

Is this student able to participate in all physical activity? Yes[ ] No[ ] If "No" what activities are to be eliminated: __________________________

Name of examiner (type or stamp) __________________________

Date: __________________________

Examiner signature: __________________________

Telephone: __________________________
Consent for Treatment/Patient Rights

I hereby authorize the Health Services staff at the SUNY Oneonta Student Health Center to use information from my health history and record to administer health care. I further authorize Health Center Staff to perform any medical examinations and treatments, diagnostic procedures, vaccinations and immunizations related to my health care during my enrollment as a student at SUNY Oneonta. In addition, I understand:

• I may be asked to give a specific consent for certain medical procedures.
• I have the right to refuse diagnostic or treatment services, or to revoke this consent.
• Services are available only to current enrolled SUNY students. Some services are covered by the student health fee.
• I have the right to be seen in a timely manner, to receive quality care, to be treated with respect and to receive feedback from my service provider.
• In order to provide the best possible treatment my provider may consult with other professionals within the SUNY Oneonta Student Health Center about issues directly related to my treatment.
• Any information which is part of my medical records at the Health Center will be treated with the strictest confidentiality. These include:
  1. state reportable conditions, such as meningitis and specific sexually transmitted infections, which constitute public health risks;
  2. threat of immediate danger to self or others, as for example, in the case of suicide or homicide;
  3. any incidence of suspected elder or child abuse, neglect, or maltreatment in order to protect the elderly and/or children involved; and
  4. in legal cases, clinicians or clinical records may be subpoenaed by the court.

I also understand that in the event of a medical emergency, information needed to provide appropriate treatment may be disclosed. Otherwise, I understand that confidential information will not be disclosed without my written/verbal authorization to do so.

I am responsible for the following:

  1. Respectful interactions with the staff.
  2. Attendance at scheduled appointments unless rescheduled or cancelled at least 24 hours in advance.
  3. Active participation and cooperation in the treatment process.
  4. Notify my treatment provider if my problem or condition worsens.

I have read the above material regarding Health Services procedures and understand these provisions. I have addressed my questions regarding this consent with a staff member. I also understand that this consent will remain in effect until I am no longer a SUNY Oneonta student.

______________________________   ______________________________
Signature                        Date

STUDENTS UNDER 18

To Parents and Guardian of Applicants under Eighteen: In order to provide quick and emergent care that may be necessary for our students and at the same time to protect the physicians and institution involved, it is requested that you sign the consent for emergency treatment.

Be assured we make every effort to notify parents at once in case of serious accidents or illness when these come to our attention, but since students often come from great distances, this may be slow or impossible even by phone. Your cooperation in this matter, therefore, is much appreciated.

Consent of parent/guardian of students under 18 for emergency medical treatment.

I, __________________________________________, as Parent-Guardian of ________________________________, age ______, of ________________________________, do hereby authorize the medical staff of the State University following unsuccessful, reasonable attempts by the college to contact me, to exercise for me and on my behalf, all my rights and duties with reference to consenting to appropriate medical, psychiatric, and surgical treatment, anesthetics, medicines, and hospitalization, including care and treatment by the Student Health Service or staff surgeon, physician, or radiologist which they may deem necessary for the emergency care of my son/daughter.

______________________________   ______________________________
Full Name                        Date