Villa Maria
—COLLEGE—

CONFIDENTIAL STUDENT HEALTH FORM

Official Use Only:
r _____ c _____

PART I

NAME _____
Last First Middle

ADDRESS _____
Street City State Zip Code

TELEPHONE (____) _____ SOCIAL SECURITY NUMBER _____

DATE OF BIRTH _____ PROGRAM OF STUDY _____

EMERGENCY CONTACT _____
Name Relationship Telephone Number

FAMILY PHYSICIAN _____ TELEPHONE NUMBER _____

HIGH SCHOOL _____ YEAR OF HIGH SCHOOL GRADUATION _____

NAME OF ANY OTHER COLLEGE ATTENDED SINCE FALL OF 1990 _____

MILITARY ONLY (OPTIONAL)—DO YOU HAVE PROOF OF HONORABLE DISCHARGE (DD214) FROM THE ARMED SERVICES WITHIN THE PAST 10 YEARS? _____

PART II

	Medical Problems:	*Medications or treatment for medical problems:*
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Operations: _____

Severe Injuries: _____

Do you have any disabilities? _____ If yes, please explain: _____

Do you require any medication for a bee sting? _____ If yes, what? _____

List any drug or food allergies: _____

PART III—TO BE COMPLETED AND SIGNED BY STUDENT OR PARENT/GUARDIAN FOR STUDENT UNDER THE AGE OF 18. MENINGOCOCCAL (ONE DOSE RECOMMENDED BY NYS PHL 2167)

I HAVE: OR FOR STUDENTS UNER THE AGE OF 18, MY CHILD HAS: *(CHECK ONE (1) BOX ONLY)*

☐ had the meningococcal meningitis immunization within the past 10 years.
Date received: _____/_____/_____
m d y

☐ 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.

STUDENT SIGNATURE OR PARENT/GUARDIAN SIGNATURE IF STUDENT IS UNDER 18 YEARS OF AGE:

SIGNED _____ **DATE** _____

PLEASE NOTE: The Health Office of Villa Maria College does not administer any vaccinations. This information is to be used by the Health Office Staff as a reference and to determine compliance with NYS Public Health Laws 2165 and 2167.

(SEE OTHER SIDE)

MEASLES, MUMPS, AND RUBELLA IMMUNITY

ATTENTION: STUDENTS BORN ON OR AFTER JANUARY 1, 1957
IT'S THE LAW: NO SHOTS, NO COLLEGE!

New York State Public Health Law 2165 requires all students born on or after January 1, 1957, and/or post-secondary students attending colleges and universities to demonstrate proof of immunity to measles, mumps, and rubella. This law applies to anyone who is taking six (6) or more credit hours. The law requires that the student be withdrawn from the college if proof of immunity is not provided within thirty (30) days of the start of classes.

IMMUNIZATION RECORD

NAME _____

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH _____/_____/_____
m d y

INSTRUCTIONS: If a physician does not sign this form, official proof of immunization must be attached. Any vaccines given before 1969 must be proven to be live vaccine without gamma globin. All dates should include month, day, and year. Please type or print clearly and **specify if vaccine is MMR**.

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.

OR 2. Date of Measles Titer and Result (copy of lab report must be attached)
Date: _____/_____/_____ Result: _____

OR 3. Date of Physician Diagnoses Measles: _____/_____/_____

REQUIRED: MUMPS IMMUNITY
Must have one of the following:
1. Date of one 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 (copy of lab report must be attached)
Date: _____/_____/_____ Result: _____

OR 3. Date of Physician Diagnoses Mumps: _____/_____/_____

REQUIRED: RUBELLA (GERMAN MEASLES) IMMUNITY
Must have one of the following:
1. Date of one 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 (copy of lab report must be attached)
Date: _____/_____/_____ Result: _____

History of Rubella illness is NOT acceptable.

The above information has been validated by:

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

_____
STREET *CITY* *STATE* *ZIP CODE*

(____)_____ _____
TELEPHONE NUMBER *DATE*

Return this completed form to the Villa Maria College Health Office, 240 Pine Ridge Road, Buffalo, NY, 14225
Please keep a copy of the completed form for your permanent record.

● *Villa Maria College Health Office Telephone Number: (716) 961-2852 ● Fax Number: (716) 896-0705* ●