DAEMEN COLLEGE UPHOLDS THE NEW YORK STATE LAW WHICH REQUIRES EACH STUDENT TO FILE A RECORD OF A MEDICAL EXAMINATION AND HEALTH HISTORY WITH THE CAMPUS PRIOR TO ATTENDANCE.

An official written request for transfer of the records must be sent by the student to the record holder with permission for the medical release of the records to Daemen College.

This information is confidential. It is strictly for Health Services use and will not be released to anyone without your knowledge and consent.

Full clearance for course registration cannot be granted until all pre-entrance medical requirements have been met. These include:

- **Documentation of immunity to Measles, Mumps, and Rubella.**
  New York State Law requires that all persons accepted to college must provide proof of immunity to Measles, Mumps, and Rubella if born on or after January 1, 1957. This can be done with the administration of two MMR vaccines OR:

<table>
<thead>
<tr>
<th>Measles (Rubeola)</th>
<th>TWO doses of live measles vaccine given after 12 months of age and after 1968 OR a positive measles titer (copy of lab report must be submitted)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mumps</td>
<td>ONE dose of mumps vaccine given after 12 months of age and after 1969 OR a positive mumps titer (copy of lab report must be submitted)</td>
</tr>
<tr>
<td>Rubella</td>
<td>ONE dose of rubella vaccine given after 12 months of age and after 1968 OR a positive rubella titer (copy of lab report must be submitted)</td>
</tr>
</tbody>
</table>

- **Tuberculosis (TB) Screen** (page 2) to be completed by a health care professional.
- **Informed decision regarding meningitis vaccine** (page 3).
  Vaccine must have been administered within the past FIVE (5) years.
- **Documentation of immunity to Hepatitis B** by means of the series of three (3) Hepatitis B immunizations OR a positive Hepatitis B titer (copy of lab report must be submitted).
- **Documentation of immunity to Varicella (Chicken Pox)** by means of two (2) Varicella immunizations OR date of physician diagnosed disease OR a positive Varicella titer (copy of lab report must be submitted).
- **Administration of Td/TDap toxoid** within the past ten (10) years.
- **Medical History** (page 3)
- **Physical Exam** (page 3)

WHEN COMPLETED, FAX (page 2 & 3 only) OR MAIL DIRECTLY TO:
Daemen Health Services Office – MB #104
4380 Main Street ● Amherst, NY 14226-3592
Phone: 716.839.8446 ● Fax: 716.839.8230
### Part 1  STUDENT INFORMATION

**REQUwRED**

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Last</td>
<td>First</td>
<td>Middle</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Social Security #</th>
</tr>
</thead>
<tbody>
<tr>
<td>City</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td></td>
</tr>
<tr>
<td>Zip</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preferred Phone #</th>
<th>First time Enrolling</th>
<th>Gender</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>( )</td>
<td>□ Summer 20 ______</td>
<td>□ Male</td>
<td>□ Resident</td>
</tr>
<tr>
<td></td>
<td>□ Fall 20 ______</td>
<td>□ Female</td>
<td>□ Commuter</td>
</tr>
<tr>
<td></td>
<td>□ Spring 20 ______</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Freshman</td>
<td>□ Transfer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Graduate Student</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Do you have Health Insurance?** □ No □ Yes

If YES - Name of Health Insurance Company

**If YES - Social Security #** - -

All students who live on campus, all student-athletes, all international students, and students in health-related fields of study while participating in clinical experiences **MUST HAVE HEALTH INSURANCE COVERAGE** and must supply a copy of the front and back of their primary health insurance card at the beginning of each academic calendar year. If your insurance carrier changes anytime throughout the year, you must submit a copy of the new insurance card. Students who reside in downstate NY or outside of New York State must supply a copy of out-of-state/network coverage verifying valid coverage in the Amherst area. **International Students will be enrolled in the Daemen College Student Health Plan.** This plan is available to any student taking six (6) credits or more.

Please list any allergies, current medications, and/or health conditions:

________________________________________________________________________________________________________

**Emergency Contact**

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Phone #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>( )</td>
</tr>
</tbody>
</table>

**PERMISSION FOR TREATMENT OF STUDENTS UNDER 18 YEARS OF AGE**

Every effort will be made to reach parents, guardians or spouse if a serious medical condition arises. If we are unable to make contact, the signature below indicates that Daemen College has permission to seek treatment for and/or hospitalize the above student.

X

Signature of Parent/Guardian/Spouse

**Part 2  MANDATORY TUBERCULOSIS SCREENING**

**Sections A and B are REQUIRED for ALL students**

**SECTION A: History of Tuberculosis (TB)?**

1. Have you ever been sick with tuberculosis? YES NO
2. Have you ever had a positive PPD, TB QuantiFERON test, or T-SPOT? YES NO

**SECTION B: At Risk for Tuberculosis (TB)?**

1. Are you currently in a health-related academic program/major? YES NO
2. Were you born in, or have you lived, worked or visited for more than one month in any of the following: Asia, Africa, South America, Central America or Eastern Europe? YES NO
   - Reason (please circle) Born there Tourist Work School Other ____________
   - How long? ____________
3. Have you had HIV infection, AIDS, diabetes, leukemia, lymphoma or a chronic immune disorder? YES NO
4. Do any of the following conditions or situations apply to you?
   a. Do you have a persistent cough (3 weeks or more), fever, night sweats, fatigue, loss of appetite, or weight loss? YES NO
   b. Have you ever lived with or been in close contact to a person known or suspected of being sick with TB? YES NO
   c. Have you ever lived, worked, or volunteered in any homeless shelter, prison/jail, hospital or drug rehabilitation unit, nursing home or residential healthcare facility? YES NO

If you answered NO to all of the above questions, skip Section C.
If you answered YES to any of the above questions, your health care provider must complete Section C below.

**SECTION C: Tuberculin Testing**

**CHEST X-RAY REQUIRED FOR POSITIVE TEST RESULT**

<table>
<thead>
<tr>
<th>PPD</th>
<th>Date Placed</th>
<th>Date Read</th>
<th>Result</th>
</tr>
</thead>
</table>

- OR -  **Quantiferon TB Gold**

| (Attach lab Report) | Date | Result |

- OR -  **T-SPot**

| (Attach lab Report) | Date | Result |

**CHEST X-RAY REQUIRED FOR POSITIVE TEST RESULT**

<table>
<thead>
<tr>
<th>Date of Chest X-ray</th>
<th>Result (attach lab report)</th>
</tr>
</thead>
</table>

Did/Will student complete a course of INH or other TB treatment? Yes No

If YES, medication _______________________________

# months student will/did take medication ____________

Date Range of Treatment ____________ to ____________
Part 3  IMMUNIZATION RECORDS

**REQUIRED**

Must be completed and signed by health care provider or attach official immunization records from previous school, health care provider or government agency.

**MMR (Measles, Mumps, Rubella)**

As mandated by New York State Public Health Law §2165, proof is required if born on or after January 1, 1957.

<table>
<thead>
<tr>
<th>Vaccination</th>
<th>Vaccine Date(s) (month/date/year)</th>
<th>OR Serology Results/Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 MMRs (combo measles, mumps, rubella vaccine)</td>
<td>#1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>#2</td>
<td></td>
</tr>
</tbody>
</table>

**OR list individual vaccines below**

<table>
<thead>
<tr>
<th>2 MEASLES (Rubella)</th>
<th>Vaccine Date(s) (month/date/year)</th>
<th>OR Serology Results/Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st dose after 1st birthday</td>
<td>#1</td>
<td></td>
</tr>
<tr>
<td>2nd dose at least 28 days later</td>
<td>#2</td>
<td></td>
</tr>
</tbody>
</table>

**1 MUMPS**

After 1st birthday

**1 RUBELLA**

After 1st birthday

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**MENINGITIS INFORMATION**

New York State Public Health Law §2167 requires students to be informed about Meningitis and be aware of the availability of meningitis vaccines. While you are not required to receive this vaccine, we strongly urge you to read the full information regarding meningitis on page 4 of this document as well as discuss the importance of having BOTH the MCV4 and SeroB vaccine strains with your physician.

**Mark one of the statements below and provide your signature:**

- I have read, or have had explained to me, the information regarding meningococcal disease, and
- have received the immunization for meningitis within the past FIVE (5) years.

<table>
<thead>
<tr>
<th>Vaccination</th>
<th>Vaccine Date(s) (month/date/year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meningitis MCV4</td>
<td></td>
</tr>
<tr>
<td>Bexsero 2 dose</td>
<td></td>
</tr>
<tr>
<td>Trumebma 3 dose</td>
<td></td>
</tr>
</tbody>
</table>

X

Signature of student, 18 years of age and older
Date

Signature of parent/guardian, under 18 years of age

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**ADDITIONAL VACCINES**

**REQUIRED**

<table>
<thead>
<tr>
<th>Vaccination</th>
<th>Vaccine Date(s) (month/date/year)</th>
<th>Titer Date (attach lab report)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus/Diphtheria (within 10 years)</td>
<td>□ Td</td>
<td></td>
</tr>
<tr>
<td>□ TDap</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Varicella (Chicken Pox) #1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Varicella (Chicken Pox) #2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Varicella (Chicken Pox) Disease Date #3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Hepatitis B #1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Hepatitis B #2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Hepatitis B #3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SUGGESTED**

- Human Papilloma (HPV)
- Hepatitis A
- Flu Shot (most recent)

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**Part 4  MEDICAL HISTORY

**REQUIRED**

- Medication Allergies: ____________________________
- Other Allergies: ____________________________
- Current Medications & Dosage: ____________________________
- Medical/Psychological Conditions: ____________________________

□ No
□ Yes – please explain __________________________________________________

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**Part 5 PHYSICAL EXAMINATION **

**REQUIRED**

Any physical exam within the past year is acceptable. Student-athletes must have a physical exam within six (6) months of sport participation.

**Date of Exam _______/_____/______**

<table>
<thead>
<tr>
<th>Height</th>
<th>Blood Pressure</th>
<th>Weight</th>
<th>Pulse</th>
</tr>
</thead>
</table>

□ EXAM ENTIRELY NORMAL

Any significant history, communicable diseases, abnormal exam findings, treatment for medical or emotional conditions, regular medications or special care for this student? *(attach if necessary)*

□ No
□ Yes – please explain __________________________________________________

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**PARTICIPATION IN SPORTS**

Recommended for physical activities, including participation in club, intramural & intercollegiate sports:

- Unlimited
- Limited – please explain __________________________________________________

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**HEALTH CARE PROVIDER INFORMATION **

**REQUIRED**

Signature of Health Care Provider
Print/Stamp Provider Name, Address & Phone Number (with area code)

Today’s Date
Meningococcal Disease
Fact Sheet

What is meningococcal disease?
Meningococcal disease is caused by bacteria called Neisseria meningitidis. It can lead to serious blood infections. When the linings of the brain and spinal cord become inflamed, it is called meningitis. The disease strikes quickly and can have serious complications, including death. Anyone can get meningococcal disease. Some people are at higher risk. This disease occurs more often in people who are:

• Teenagers or young adults
• Infants younger than one year of age
• Living in crowded settings, such as college dormitories or military barracks
• Traveling to areas outside of the United States, such as the “meningitis belt” in Africa
• Living with a damaged spleen or no spleen
• Being treated with Soliris® or, who have complement component deficiency (an inherited immune disorder)
• Exposed during an outbreak
• Working with meningococcal bacteria in a laboratory

What are the symptoms?
Symptoms appear suddenly – usually 3 to 4 days after a person is infected. It can take up to 10 days to develop symptoms. Symptoms may include:

• A sudden high fever
• Headache
• Stiff neck (meningitis)
• Nausea and vomiting
• Red-purple skin rash
• Weakness and feeling very ill
• Eyes sensitive to light

How is meningococcal disease spread?
It spreads from person-to-person by coughing or coming into close or lengthy contact with someone who is sick or who carries the bacteria. Contact includes kissing, sharing drinks, or living together. Up to one in 10 people carry meningococcal bacteria in their nose or throat without getting sick.

Is there treatment?
Early diagnosis of meningococcal disease is very important. If it is caught early, meningococcal disease can be treated with antibiotics. But, sometimes the infection has caused too much damage for antibiotics to prevent death or serious long-term problems. Most people need to be cared for in a hospital due to serious, life-threatening infections.

What are the complications?
Ten to 15 percent of those who get meningococcal disease die. Among survivors, as many as one in five will have permanent disabilities. Complications include:

• Hearing loss
• Brain damage
• Kidney damage
• Limb amputations

What should I do if I or someone I love is exposed?
If you are in close contact with a person with meningococcal disease, talk with your health care provider about the risk to you and your family. They can prescribe an antibiotic to prevent the disease.

What is the best way to prevent meningococcal disease?
The single best way to prevent this disease is to be vaccinated. Vaccines are available for people 6 weeks of age and older. Various vaccines offer protection against the five major strains of bacteria that cause meningococcal disease:

• All teenagers should receive two doses of vaccine against strains A, C, W and Y. The first dose is given at 11 to 12 years of age, and the second dose (booster) at age 16.
• It is very important that teens receive the booster dose at age 16 in order to protect them through the years when they are at greatest risk of meningococcal disease.
• Talk to your health care provider today if your teen has not received two doses of vaccine against meningococcal strains A, C, W and Y.
• Teens and young adults can also be vaccinated against the “B” strain. Talk to your health care provider about whether they recommend vaccine against the “B” strain.

Others who should receive the vaccine include:

• Infants, children and adults with certain medical conditions
• People exposed during an outbreak
• Travelers to the “meningitis belt” of sub-Saharan Africa
• Military recruits

Please speak with your health care provider if you may be at increased risk.

What are the meningococcal vaccine requirements for school attendance?
As of September 1, 2016, children entering grades 7 and 12 must be immunized against meningococcal disease strains A, C, W and Y according to the recommendations listed above.

Is there an increased risk for meningococcal disease if I travel?

• Meningococcal disease and outbreaks occur in the United States and around the world. The disease is more common in the “meningitis belt” of sub-Saharan Africa. The risk is highest in people who visit these countries and who have prolonged contact with local populations during an epidemic.
• To reduce your risk of illness, wash your hands often, maintain healthy habits such as getting plenty of rest and try not to come into contact with people who are sick.

Learn more about meningococcal disease:
www.cdc.gov meningococcal/

For more information about vaccine-preventable diseases:
www.health.ny.gov/prevention/immunization/