NEW STUDENT HEALTH FORM

BUFFALO STATE
The State University of New York

You will not be allowed to register for classes unless this document is completed, signed, and filed with the Weigel Health Center. Complete all sections. Fax form to: (716)878-6727 or email to newstudenthealthform@buffalostate.edu

STUDENTS CANNOT REGISTER FOR CLASSES UNTIL THEY HAVE FUFILLED THE REQUIRED IMMUNIZATIONS

- Form must be completed and signed by a licensed health care provider or have immunization records attached.
- All immunization records must be in English.

Name (please print): _____ Banner ID: _____
LAST FIRST MI

Birthdate: _____ / _____ / _____ Emergency Contact Name & Phone #: _____
MONTH DAY YEAR

FOR STUDENTS UNDER 18 YEARS OF AGE ONLY

To avoid delays when medical problems arise, we request that the following statement be signed by a parent or legal guardian:
I hereby grant permission to Weigel Health Center to provide services, including telemedicine, to my child. This includes care and treatment by medical providers at any outside health care facility if deemed necessary by Weigel Helth Center.

PARENT/GUARDIAN SIGNATURE RELATIONSHIP DATE

REQUIRED FOR ALL STUDENTS	SUBMIT DATES IN MONTH/DAY/YEAR FORMAT
MMR (COMBINED MEASLES, MUMPS, RUBELLA) New York State Public Health Law requires all documentation of: • Two Doses of MMR vaccine (given after 01/01/1968); both administered after first birthday and at least 28 days apart. Individual measles, mumps, and rubella vaccines are also acceptable. **OR** • Serology (blood test): *Positive IgG antibody titers confirming immunity to measles, mumps, and rubella.	Dose #1: _____ / _____ / _____ Dose #2: _____ / _____ / _____ **OR** MMR Titer* Date: _____ / _____ / _____ ***MUST ATTACH LAB REPORTS WITH REFERENCE RANGE**
MENINGOCOCCAL VACCINE OR WAIVER New York State Public Health requires all college students to: • Receive at least one dose of Meningococcal ACWY containing vaccine within 5 years of entering college. **OR** • Receive two doses (full series) of Meningococcal B. vaccine. **OR** • Sign a waiver specifically declining meningococcal immunization after reading the information about meningococcalmeningitis disease, found here: https://www.health.ny.gov/publications/2168/	Dose #1 _____ / _____ / _____ Check: ☐ ACWY or ☐ ABWY Dose #2 _____ / _____ / _____ Check: ☐ ACWY or ☐ ABWY **OR** Men B Dose #1 _____ / _____ / _____ Men B Dose #2 _____ / _____ / _____ **OR** I acknowledge the risks associated with meningococcal infection (meningitis) and decline immunization at this time. SIGNATURE DATE **If student is under 18 years of age, parent/guardian must sign & date.**
TETANUS-DIPHTHERIA (RECOMMENDED) • Tetanus (Td/Tdap) booster within last 10 years • One lifetime adult Tdap (contains pertussis) is required • Must complete both fields even if the date is the same	Most recent Tetanus _____ / _____ / _____ Check: ☐ Td or ☐ Tdap Adult Tdap Vaccine: _____ / _____ / _____ **MUST COMPLETE BOTH FIELDS EVEN IF THE DATE IS THE SAME**

HEALTH CARE PROVIDER SIGNATURE REQUIRED TO CERTIFY IMMUNIZATIONS IN SECTION

HEALTH CARE PROVIDER SIGNATURE DATE

HEALTH CARE PROVIDER NAME (PRINT/STAMP) HEALTH CARE PROVIDER ADDRESS & PHONE NUMBER (PRINT/STAMP)

TUBERCULOSIS SCREENING

PARTS A & B REQUIRED FOR ALL STUDENTS. PART C IS REQUIRED IF YES TO ANY QUESTIONS IN PARTS A OR B

PART A

CHECK

1. Have you ever had a positive PPD, TB QuantiFERON, or T-SPOT test? ☐ YES ☐ NO

PART B

1. Are you currently enrolled *(not intended)* in a health-related program (Athletic Training, Communicative Disorders, Dental, Dietetic Intern, Exercise Science, Medicine, Med Tech/Bio Tech, Nuclear Med, Nursing OT, Pharmacy, PT)? ☐ YES ☐ NO
2. Were you born in or have you resided for more than one month in a country other than the U.S., Canada, Austrailia, New Zealand or those in Northern or Western Europe? ☐ YES ☐ NO

If yes, what country? _____ How long? _____

3. Do any of the following conditions or situations apply to you?
   a. Have you been in close contact to someone who has infectious TB infection since your last TB test? ☐ YES ☐ NO
   b. Have you ever lived, worked, or volunteered in congregate settings (e.g., prisons, nursing homes, homeless shelters, drug treatment facilities or healthcare facilities)? ☐ YES ☐ NO
   c. Do you have a medical condition or are you taking medication which suppresses your immune system? ☐ YES ☐ NO
   d. Have you had the BCG vaccination? ☐ YES ☐ NO

STUDENT SIGNATURE DATE

PART C: IF "YES" TO ANY OF THE QUESTIONS ABOVE, IT IS REQUIRED THAT THE FOLLOWING SECTION BE COMPLETED BY A MEDICAL PROVIDER.

- If the student has answered YES to any of the above questions, a TB test (PPD, T-SPOT, or TB QuantiFERON {QFT}) IS REQUIRED. TB test must be completed within one calendar year (unless history of positive TB test — see below). MUST ATTACH LAB REPORT IF T-SPOT OR QFT IS COMPLETED
- If PPD result is 10mm or more, or T-SPOT or QFT is positive, a chest x-ray is REQUIRED.
- If the student has a history of a postitive TB test, document date and result of the test and chest x-ray, as well as treatment information. It is not necessary for students with a history of positive TB test & normal chest x-ray to repeat TB testing or the chest x-ray.
- History of BCG vaccination does not exclude the student from this requirement.

PPD Date Placed:	PPD Date Read:	Induration/ Measurement (in mm):

OR

Check Test ☐ QFT or ☐ T-SPOT ***MUST ATTACH LAB REPORT**	Date of Collection: _____ / _____ / _____	Check Result ☐ Positive ☐ Negative	An intermediate, equivocal, borderline or invalid result in not acceptable. Repeat testing will be necessary.

***Chest X-ray REQUIRED IF PPD > 10mm or Positive QFT/T-SPOT. Please attach copy of radiology report.**

Chest X-ray Date:	Chest X-ray Result:

1. Does the student have any of the following symptoms: cough with sputum production > 3 weeks, bloody sputum, unintended weight loss > 10 pounds, drenching night sweats, unexplained fever, fatigue > 3 weeks? ☐ YES ☐ NO
   **If yes, student must be evaluated by a medical provider to rule out active TB infection*
2. If positive TB test & normal chest x-ray, did the student complete a course of INH or other TB treatment? ☐ YES ☐ NO
   a. If yes, name & dose of medication _____
   b. Date and range of treatment Number of months of treatment _____

HEALTH CARE PROVIDER SIGNATURE DATE

HEALTH CARE PROVIDER NAME (PRINT/STAMP) HEALTH CARE PROVIDER ADDRESS & PHONE NUMBER (PRINT/STAMP)