



# Accelerated Degree Program Student Health Forms

Required by New York State Public Health Law

**Return completed forms in enclosed envelope to:**

Concordia College New York  
Attn: Student Health Center  
171 White Plains Rd  
Bronxville, NY 10708

**Or scan forms and email to:**

[Susan.Crane@concordia-ny.edu](mailto:Susan.Crane@concordia-ny.edu)

## IMPORTANT

**NO** student will be permitted to attend class until forms are returned.

**ALL** students must complete the Personal Health Form and Meningitis Disclosure.

If you were born before January 1, 1957, immunization records are **NOT** required.

### Questions?

Contact the Student Health Services Office

[Susan.Crane@concordia-ny.edu](mailto:Susan.Crane@concordia-ny.edu)

914.337.9300 x2243

Revised: **NOVEMBER 2019**

## IMPORTANT INSTRUCTIONS

### SECTION 1

#### Personal Health History and Emergency Contact Information

### SECTION 2

#### Measles, Mumps, & Rubella Immunizations: **PROOF OF IMMUNIZATION MUST BE ATTACHED**

New York State Vaccination Law 2165 and Concordia College require verification of vaccination or immunity for every registered Concordia student born after Jan. 1, 1957 documenting proof of immunity to Measles, Mumps, and Rubella.

**MMR:** Two (2) doses are required for entry into Concordia College. The first dose must have been received on or after the 1<sup>st</sup> birthday.

**OR**

Immunity may be proven by a blood test for antibodies. Lab reports must be submitted and the provider must sign and stamp lab reports.

**OR**

**Measles (Rubeola):** Two (2) doses are required. The first dose must have been received on or after the 1<sup>st</sup> birthday.

**Mumps:** One (1) dose is required and must have been received on or after the 1<sup>st</sup> birthday.

**Rubella (German measles):** One (1) dose is required and must have been received on or after the 1<sup>st</sup> birthday. A previous history of having Rubella is *not* acceptable proof of immunity.

If you have attended another college, community college or university within the last 5-7 years, you provided the previous college with the same immunization records we require. Your former college's Health Office may fax your records (even if they are on your previous college's form) to our office at (914) 395-4521.

### SECTION 3

#### Meningococcal Vaccine **PLEASE READ CAREFULLY**

As per New York State Public Health Law 2167, **all students residing in campus housing must have the vaccine.** If you are a commuting student and have not had the vaccine, you must sign a waiver stating you have read about the disease and decline the vaccine. It is highly recommended that all students have the meningitis vaccine.

**SEC I: Personal Health History (TO BE COMPLETED BY STUDENT)**

This is a confidential record. Information you provide will be used solely as an aid to providing health care while you are a student.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Home Address: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Preferred email address: \_\_\_\_\_ Work phone: \_\_\_\_\_

Personal Information: Age: \_\_\_\_\_ Gender: Male \_\_\_\_\_ Female \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_

Have you attended Concordia College before?  Yes  No

If **YES**, what was the **LAST** year you attended? \_\_\_\_\_

If **YES**, what was your last name when you attended last? : \_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_ Number: \_\_\_\_\_

**Personal History:**

Please answer all questions. Comment on all positive answers in space allowed.

Do you have Allergies to:	Yes	No
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Sulfonamides (i.e. Keflex, Bactrim)	<input type="checkbox"/>	<input type="checkbox"/>
Foods (list below)	<input type="checkbox"/>	<input type="checkbox"/>
Other Medications	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

- A. Has your physical activity been restricted during the past five years? Yes No (If yes, explain below.)
- B. Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem?  
Yes No (If yes, give details below.)
- C. Have you had any illness or injury or been hospitalized other than already noted? Yes No (If yes, give details below.)
- D. Have you consulted or been treated by clinics, physicians, or other practitioners within the past five years?  
(other than routine checkups?) Yes No
- E. Do you smoke, dip, or chew tobacco? Yes No
- F. Do you have any chronic medical conditions such as Hypertension, Asthma, Diabetes, etc.? (If you are under care by a medical professional for a chronic or serious illness, please describe below in order to assist us in providing you care if necessary.)
- G. Do you take any medication at present? Yes No (If Yes, Please list below)

Comments: \_\_\_\_\_

**Medical and Surgical Authorization** In case of illness and/or injury, authority and consent is given to Concordia College for examination and treatment of named student either at the Health Center, Concordia College, or by outside physicians and medical facilities as are available. Consent is further given for admission to a hospital for necessary medical or surgical treatments as ordered by a physician. It is agreed that all medical and/or hospital expenses incurred beyond those covered by any applicable student insurance policy will be paid directly and promptly by the undersigned student and parents or guardians and the College will not be held responsible.

Date \_\_\_\_\_ Student's Signature \_\_\_\_\_ Age \_\_\_\_\_

## HOW TO OBTAIN PROOF OF IMMUNIZATION COMPLIANCE

Dear Adult Student:

Under **New York State Public Health Law 2165**, every student born *after* January 1, 1957, and registered for six (6) or more credits per semester must provide proof of having been immunized with two (2) doses of the MMR (measles, mumps, rubella) vaccine.

**We understand that you may not have your childhood immunization records easily accessible, so we have prepared this list of options to help you to prove immunization or immunity. ONLY ONE OPTION IS REQUIRED.**

1. Provide evidence that a health care provider has administered two (2) doses of MMR vaccine, signed and stamped by the provider.
2. Provide evidence that a health care provider has administered one (1) dose of measles vaccine and one (1) dose of MMR vaccine, signed and stamped by the provider.
3. Show **positive** immunity through blood titers for **all 3 diseases**. \*NOTE: A negative titer on any of the 3 diseases requires a follow-up vaccine or vaccines! Do not submit a negative titer without proof of a follow-up vaccine. A negative measles requires two (2) MMR vaccines; a negative mumps or rubella requires one (1) MMR vaccine.
4. Honorable Discharge from the Military: Provide a copy of your honorable discharge from any branch of The United States Armed Forces within 10 years from the date of application to Concordia while you wait for **pending and definitive evidence** of having received the required vaccines.
5. Religious Waiver: Provide, in writing, your genuine and sincere religious beliefs of why you do not wish to receive the vaccine(s).
6. Previous College Records: Request copies of your medical records from the college you previously attended. Depending on the college's policy, records may only be kept for 5-7 years.

If none of these scenarios are available to you, we can administer the MMR vaccine in the Student Health Center. The vaccine is administered subcutaneously (under the skin) and each dose, a total of two (2), are administered no less than 30 days apart. We can also draw blood titers and have arranged a price with our lab for those whose insurance does not cover titers or those who do not have insurance at this time.

Please call the **Health Center at (914) 337-9300, x2243** with any questions you may have or to schedule an appointment.

Sincerely,



**Susan Crane, RN Director of Student Health Services**

**MANDATORY MEASLES, MUMPS, RUBELLA VACCINE REQUIREMENTS  
(TO BE COMPLETED BY HEALTH CARE PROVIDER)**

\*You May Attach Lab or Immunization Reports

Student's Name: \_\_\_\_\_ Concordia ID# C \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

E-mail: \_\_\_\_\_

Student Type:  Adult Education .

Health Care Provider (please print) \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Fax:(\_\_\_\_) \_\_\_\_\_

Provider's Signature: \_\_\_\_\_

**I. REQUIRED IMMUNIZATIONS for ALL students born after 1/01/57**

**Section A. MMR (Measles, Mumps, Rubella; was not available in the U.S. before 1/1/72)**

Month/Day/Year

\_\_\_\_<sup>st</sup> 1 MMR Dose (Administered after 1<sup>st</sup> birthday AND after 1/1/1972)  
\_\_\_\_/\_\_\_\_/\_\_\_\_

**AND**

\_\_\_\_<sup>ND</sup> 2 MMR Dose (Administered after 15 months of age and at least 28 days after 1<sup>st</sup> dose)  
\_\_\_\_/\_\_\_\_/\_\_\_\_

**Section B1. Measles**

Month/Day/Year

\_\_\_\_<sup>st</sup> 1 Live Virus Dose (Administered after 1<sup>st</sup> birthday & 1/1/69)  
\_\_\_\_/\_\_\_\_/\_\_\_\_

**AND**

\_\_\_\_<sup>nd</sup> 2 Live Virus Dose (Administered after 15 months of age and at least 28 days after 1<sup>st</sup> dose)  
\_\_\_\_/\_\_\_\_/\_\_\_\_

**OR**

\_\_\_\_ Immunity (Proven by Serologic Testing)  
\_\_\_\_/\_\_\_\_/\_\_\_\_

**Section B2. Mumps**

Month/Day/Year

\_\_\_\_ Live Virus Dose (Administered after 1<sup>st</sup> birthday & 1/1/69)  
\_\_\_\_/\_\_\_\_/\_\_\_\_ **OR** \_\_\_\_ Immunity (Proven by Serologic Testing)  
\_\_\_\_/\_\_\_\_/\_\_\_\_

**Section B3. Rubella (German Measles)**

Month/Day/Year

\_\_\_\_ Live Virus Dose (Administered after 1<sup>st</sup> birthday & 1/1/69)  
\_\_\_\_/\_\_\_\_/\_\_\_\_ **OR** \_\_\_\_ Immunity (Proven by Serologic Testing)  
\_\_\_\_/\_\_\_\_/\_\_\_\_

**Note: History of Illness is NOT acceptable**

Continued 

### Sec. III. Meningococcal Meningitis Vaccination Response Form

(To be completed by Health Care Provider or by student if waived.)

**Note\*: Only students who DO NOT reside on campus may waive the vaccine.**

**A. Meningococcal Meningitis Vaccine (Menactra™/Menomune™Menveo™):** Please consider this vaccine. Students wishing to decline this vaccine must read the information in the box below. **Signing the waiver indicates that you understand the possible risk involved in not receiving this immunization.**

**Disclosure Statement-Meningococcal Meningitis:** College students, especially first-year students living in residence halls, are at a slightly increased risk for contacting meningococcal disease. The bacterial form of this disease can lead to serious complications such as swelling of the brain, coma, and even death within a short period of time. A vaccine is currently available that will decrease, but not completely eliminate, a person's risk of acquiring meningococcal meningitis. This element of uncertainty remains because there are five (5) different serotypes (A, B, C, Y, & W-135) and the current vaccine does not offer any protection from serotype B. The vaccine, Menactra™/Menomune™ probably protects for 3-5 years, and is extremely safe for use. Menactra™ vaccine is available at the Concordia Student Health Center. For more specific information about meningococcal meningitis and college student risks, please visit the NYS DOH website at: [www.health.state.ny.us/nysdoh/immun/meningococcal/index.htm](http://www.health.state.ny.us/nysdoh/immun/meningococcal/index.htm)

**Mandatory -Read Carefully:** As per New York State Public Health Law 2167, you must either have the vaccine or sign a waiver stating you have read about the disease and decline the vaccine.

(circle one:) Menomune / Menactra

**A. Meningococcal Meningitis Vaccine (Menomune™ or Menactra™ ) given within the past 10 years:**

**B. Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

An official stamp from a doctor's office, clinic, or health department AND an authorized signature must be provided below.

\_\_\_\_\_  
Name/License#/Office Stamp

**\*Read the information provided above and sign the waiver below.**

\_\_\_\_ I have 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 will not obtain immunization against meningococcal meningitis disease.

\_\_\_\_\_  
Signature of Student

Date: \_\_\_\_\_

Print Name \_\_\_\_\_

ADULT EDUCATION STUDENT  
HEALTH SERVICES  
FAX (914) 395-4521  
TEL: (914) 337-9300 EXT. 2243