Dear Incoming Student,

Welcome to The College of Saint Rose! Each student is required to provide the following information to the College’s Health Service office. Many of these requirements are required by the New York Department of Health.

All forms need to be completed by September 16th for Fall semester, and February 6th for Spring semester.

- Complete Immunization Record. **Health Care Provider Signature Required.**
- Complete Meningococcal Meningitis Record. **Health Care Provider Signature Required.**
- Complete Medical History.

All of these forms can be uploaded to the medical portal that can be found on the Health Services website:

https://www.strose.edu/student-development/health-counseling-wellness/health-services/required-health-forms/

If you have any questions about what is required contact Health Services by email at healthservices@strose.edu or by phone at (518) 454-5244.

The Health Services clinic is open during the academic year and offer the following services:

**Same Day Services by Appointment**
- Evaluation and treatment for ACUTE ILLNESS with testing and medications
- OTC Medication dispensing
- First aid for non-life threatening injuries
- Assistance with visits to specialists and with student permission collaboration with Counseling Services as needed
- Hospital follow-up
- Personal health education

**Additional Services**
- DMV Eye Exams
- Old meds/sharps disposal
- **On Site Rapid Testing**
  - Rapid Strep
  - Rapid Flu A&B
  - Rapid Mono Spot
  - COVID-19 Rapid Antigen and Rapid Molecular
  - Rapid Urine Pregnancy

**THE HEALTH SERVICES CLINIC DOES NOT PROVIDE THE FOLLOWING SERVICES AT THIS TIME:**
- ALLERGY INJECTIONS, ORAL OR INJECTABLE BIRTH CONTROL, DAILY MEDICATIONS FOR CHRONIC ILLNESS AND PELVIC EXAMS/PAPS.

Sincerely,

Health Services
Quick Instructions for Forms

Immunization Record
New York State Law requires all students born on or after January 1, 1957 registering for six or more credits to prove immunity to measles, mumps, and rubella (MMR). **This form must be signed and stamped by a medical provider, or accompanied by an immunization record that is stamped by a medical provider.**

- 2 doses of live measles vaccine (or the combined MMR), with the 1st dose given no more than 4 days prior to the student’s first birthday and the second dose at least 28 days after the first dose.
- 1 dose of live mumps vaccine (or the combined MMR), with the 1st dose given no more than 4 days prior to the student’s first birthday.
- 1 dose of live rubella vaccine (or the combined MMR), with the 1st dose given no more than 4 days prior to the student’s first birthday

OR

- Serological proof of immunity to measles, mumps and rubella through a lab report from an approved medical laboratory confirming immunity.

Meningococcal Meningitis Record
The meningitis vaccine is not required, however, all students registering for six or more credits must submit one of the following:

- Certificate of immunization for meningococcal meningitis disease within the past five years; or
- An acknowledgement of meningococcal disease risks and refusal of meningococcal meningitis immunization signed by the student (or student’s parent or guardian if under the age of 18).

Report of Medical History
This form is required for all students and is to be completed and signed by the student (or student’s parent or guardian if under the age of 18). **A medical provider does not complete this form.**
# IMMUNIZATION RECORD

**Name:** __________________________  **Student ID:** __________________________

**Address:** __________________________  **Phone:** __________________________

**City:** __________________________  **Cell:** __________________________

**State:** __________________________  **Zip:** __________________________  **Date of Birth:** __________________________

**HEALTH CARE PROVIDER OR SCHOOL OFFICIAL PLEASE READ AND COMPLETE THIS FORM, THANK YOU.**

New York State Public Health Law 2165 requires post-secondary students to show proof of immunity to **MEASLES, MUMPS and RUBELLA**. **Persons born prior to January 1, 1957 or taking less than six credits in a semester are exempt from this requirement.** Immunization #1 in Option 1 must have been given after the first birthday.

**REQUIRED VACCINES (Option 1 or 2):**

**Option 1:** Two Doses of Measles, Mumps, Rubella (MMR) Vaccine - (Dose #1 given **after** First birthday)

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<tr>
<th>MMR #1</th>
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AND

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**Option 2:** Positive MMR Antibody Titers

( ) ✓ Positive MMR Antibody Titers

**MUST ATTACH COPY OF LAB REPORT**

Attached certificates of immunization will be accepted **ONLY IF** signed/stamped by health care provider.

**RECOMMENDED VACCINES:**

**COVID-19** All Saint Rose students are recommended to be fully vaccinated against COVID-19

Vaccine Name __________________________  example: Pfizer

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**Tetanus:**       |   |

**Varicella:**       |   |

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**Hepatitis B Series:**

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Attached certificates of immunization will be accepted **ONLY IF** signed/stamped by health care provider

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**Health Care Provider Signature & Stamp Required**

**Stamp**

**Signature** __________________________

**Date:** __________________________

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**HEALTH SERVICES • 432 WESTERN AVE. • ALBANY, NY 12203**

(518) 454-5244 • Fax (518) 454-2007

Rev. 01.2023
MENINGOCOCCAL MENINGITIS RECORD

Name: ____________________________ Student ID: ____________________________
Address: ____________________________ Phone: ____________________________
City: ____________________________ Cell: ____________________________
State: __________________ Zip: ____________________________ Date of Birth: __________________

At least 1 dose of Meningococcal ACWY vaccine not more than 5 years before enrollment is recommended.

(Meningitis vaccination or waiver is REQUIRED of all students– See Below for Student Waiver)

Recommended Vaccine:
MENINGOCOCCAL ACWY Name ____________________________ Date: ___________/
Month Day Year

MENINGOCOCCAL ACWY Name ____________________________ Date: ___________/
Month Day Year

Health Care Provider Signature & Stamp Required
Stamp: ____________________________ Signature: ____________________________
Date: ____________________________

Attached certificates of immunization will be accepted ONLY IF signed & stamped by health care provider.

STUDENT WAIVER

Required Meningococcal Meningitis Response

TO BE COMPLETED BY STUDENT OR PARENT/GUARDIAN

Please review the vaccine information on the back of this form. If you have chosen not to have the meningitis vaccine, complete the following waiver by signing and dating the statement below.

I have received and reviewed the Meningococcal Meningitis vaccine information provided on the back of this form. I understand the risks of Meningococcal Meningitis and the benefit of immunization and have decided that I will NOT obtain immunization against Meningococcal Meningitis

Signed: ____________________________ Date: ____________________________

Signature of Student or Parent/Guardian if student is under eighteen.

HEALTH SERVICES • 432 WESTERN AVE. ALBANY, NY 12203
PHONE 518-454-5244 • FAX 518-454-2007

Rev. 12.2021
Meningococcal Meningitis Information

The College of Saint Rose is required to maintain a record of the following for each student:

- A response to receipt of meningococcal disease and vaccine information signed by the student or student’s parent or guardian
- A record of meningococcal immunization within the past 5 years; OR
- An acknowledgement of meningococcal disease risks and refusal of meningococcal immunization signed by the student or student’s parent or guardian.

Meningococcal disease is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. Meningococcal disease can cause serious illnesses such as infection of the lining of the brain and spinal column (meningitis) or blood infections (sepsis). The disease strikes quickly and can lead to severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even lead to death.

Meningococcal disease can be easily spread from person-to-person by coughing, sharing beverages or eating utensils, kissing, or spending time in close contact with someone who is sick or who carries the bacteria. People can spread the bacteria that cause meningococcal disease even before they know they are sick. There have been several outbreaks of meningococcal disease at college campuses across the United States. Up to one in 10 people carry meningococcal bacteria in their nose or throat without getting sick.

The single best way to prevent meningococcal disease is to be vaccinated. The meningococcal ACWY (MenACWY) vaccine protects against four major strains of bacteria which cause about two-thirds of meningococcal disease in the United States (U.S.). The MenACWY vaccine is recommended for all U.S. teenagers and young adults up to age 21 years. Protection from the MenACWY vaccine is estimated to last about 3 to 5 years, so young adults who received the MenACWY vaccine before their 16th birthday should get a booster dose before entering college. The meningococcal B (MenB) vaccine protects against a fifth type of meningococcal disease, which accounts for about one-third of cases in the U.S. Young adults aged 16 through 23 years may choose to receive the MenB vaccine series. They should discuss the MenB vaccine with a healthcare provider.

All private insurance plans not grandfathered under the Affordable Care Act are required to cover the cost of MenACWY and MenB vaccines. Contact your health insurance plan to determine whether it covers MenACWY and MenB vaccines. The federal Vaccines for Children (VFC) and NYS Vaccines for Adults (VFA) programs will cover both MenACWY and MenB vaccines for children and adults who have no health insurance or whose health insurance does not cover these vaccines, as well as for children less than 19 years of age who are American Indian or Alaska Native or eligible for Medicaid or Child Health Plus.

The College of Saint Rose Health Service does not provide immunizations. Please check with your insurance provider to find participating locations and coverage. The vaccine is available through county health departments and locally at the Albany County Department of Health, 175 Green Street, Albany, NY 12202 Phone: (518) 447-4580. Prices range from $18 to $140 please call to verify eligibility.

To learn more about meningococcal disease and the vaccine, please feel free to contact our health service and/or consult your child’s physician. You can also find information about meningococcal disease and the vaccine at the Centers for Disease Control and Prevention website at www.cdc.gov/meningococcal/ and the New York State Department of Health website at www.health.ny.gov/publications/2168.pdf.
MEDICAL HISTORY

Name: ___________________________ Student ID: ___________________________
Address: ___________________________ Phone: ___________________________
City: ___________________________ Cell: ___________________________
State: ___________________________ Zip: ___________________________ Date of Birth: ___________________________

Allergies to medications, foods, or stinging insects: □ No □ Yes, List ___________________________

Medications regularly taken or required: □ No □ Yes, List ___________________________

Personal History: □ Check ✓ for: No significant medical history, no to all below. 
Or Check ✓ “Yes” and explain below or check the following box:

Cardiac Disease □ Yes, __________ Gastrointestinal Disorder □ Yes, __________
High Blood Pressure □ Yes, __________ Marfan’s Syndrome □ Yes, __________
Heart Murmur □ Yes, __________ Diabetes □ Yes, __________
Surgery □ Yes, __________ Skin Disorder □ Yes, __________
Cancer □ Yes, __________ Arthritis □ Yes, __________
Anemia □ Yes, __________ Orthopedic/Spine Disorder □ Yes, __________
Clotting Disorder □ Yes, __________ Seizure Disorder □ Yes, __________
Sickle Cell Trait □ Yes, __________ Head Injury □ Yes, __________
Asthma □ Yes, __________ Migraine □ Yes, __________
Kidney Disease/UTI □ Yes, __________ Mononucleosis □ Yes, __________
Tuberculosis □ Yes, __________ Chicken Pox □ Yes, __________
Thyroid Disease □ Yes, __________ Other □ Yes, __________

Family History

Father: □ Living □ Deceased, age at death and cause ___________________________
Mother: □ Living □ Deceased, age at death and cause ___________________________

Has any immediate family member ever had?

Cardiac Disease □ Yes □ No Marfan’s Syndrome □ Yes □ No Asthma □ Yes □ No Tuberculosis □ Yes □ No Thyroid Disease □ Yes □ No
Sudden Cardiac Death □ Yes □ No Sickle Cell Trait □ Yes □ No Seizure Disorder □ Yes □ No Stroke □ Yes □ No Clotting Disorder □ Yes □ No
High Blood Pressure □ Yes □ No Cancer □ Yes □ No Diabetes □ Yes □ No Kidney Disease □ Yes □ No DVT □ Yes □ No

Emergency contact:

Name: ___________________________ Relationship: ___________________________ Phone Number: ___________________________

CONSENT TO TREATMENT AND FINANCIAL RESPONSIBILITY

I hereby give permission for the above student to receive general, diagnostic and therapeutic medical treatment or counseling services from the College of Saint Rose Health Service, Counseling and Psychological Services or such other health care provider as The College of Saint Rose shall determine necessary. This includes examinations and treatments for all medical problems, psychological issues, and/or injuries incurred while the student is attending The College of Saint Rose and all consultative care by external health care providers including hospitalization, anesthesia, surgery or other treatments.

I hereby give permission to the Counseling Center and Health Services at The College of Saint Rose to exchange information and records relative to my medication management and mental and physical health.

This means that the Counseling Center has my authorization to release and receive records pertaining to my medication management and mental and physical health with Health Services. Additionally, Health Services has my authorization to release and receive records pertaining to my medication management and mental and physical health with the Counseling Center.

The undersigned student and parent/guardian accept financial responsibility for the expense of health care services, diagnostic and therapeutic medical treatment or counseling services rendered to the above student by The College of Saint Rose Health Service, Counseling and Psychological Services or such other health care provider as The College of Saint Rose shall determine necessary. If you have health insurance, provide the name of company and policy number. Include the phone number from back of card or attach a copy of the card.

ATHLETES ONLY I hereby give permission to Sports Medicine and Health Services at The College of Saint Rose to exchange information and records relative to my physical health.

______________________________________ ________________ ________________
Signature of Student Company name Policy number Phone Number

Rev. 04.2023