

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)

MMR #1 ____/____/____ AND MMR #2 ____/____/____
Month Day Year Month Day Year

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

____/____/____, ____/____/____, ____/____/____, ____/____/____

Tetanus: ____/____/____

Varicella: ____/____/____, ____/____/____

Hepatitis B Series: ____/____/____, ____/____/____, ____/____/____

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

Health Care Provider Signature & Stamp Required

Stamp

Signature _____

Date: _____

HEALTH SERVICES • 432 WESTERN AVE. • ALBANY, NY 12203
(518) 454-5244 • Fax (518) 454-2007

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:

A rectangular box for a stamp, currently empty.

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**

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
AND EITHER
- 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

The
College
of Saint
Rose

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	<input type="checkbox"/> Yes, _____	Gastrointestinal Disorder	<input type="checkbox"/> Yes, _____
High Blood Pressure	<input type="checkbox"/> Yes, _____	Marfan's Syndrome	<input type="checkbox"/> Yes, _____
Heart Murmur	<input type="checkbox"/> Yes, _____	Diabetes	<input type="checkbox"/> Yes, _____
Surgery	<input type="checkbox"/> Yes, _____	Skin Disorder	<input type="checkbox"/> Yes, _____
Cancer	<input type="checkbox"/> Yes, _____	Arthritis	<input type="checkbox"/> Yes, _____
Anemia	<input type="checkbox"/> Yes, _____	Orthopedic/Spine Disorder	<input type="checkbox"/> Yes, _____
Clotting Disorder	<input type="checkbox"/> Yes, _____	Seizure Disorder	<input type="checkbox"/> Yes, _____
Sickle Cell Trait	<input type="checkbox"/> Yes, _____	Head Injury	<input type="checkbox"/> Yes, _____
Asthma	<input type="checkbox"/> Yes, _____	Migraine	<input type="checkbox"/> Yes, _____
Kidney Disease/UTI	<input type="checkbox"/> Yes, _____	Mononucleosis	<input type="checkbox"/> Yes, _____
Tuberculosis	<input type="checkbox"/> Yes, _____	Chicken Pox	<input type="checkbox"/> Yes, _____
Thyroid Disease	<input type="checkbox"/> Yes, _____	Other	<input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	Marfan's Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sudden Cardiac Death	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Trait	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizure Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Clotting Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	DVT	<input type="checkbox"/> Yes <input type="checkbox"/> 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.

Company name	Policy number	Phone Number
Signature of Student _____ Date _____		

For students under age 18:

I give permission for the above named student to receive the medical treatment and counseling services and accept financial responsibility for that treatment:

Print Name of Parent/Guardian: _____

Signature of Parent/Guardian _____ **Date** _____