**NIAGARA COUNTY COMMUNITY COLLEGE**
WELLNESS CENTER
3111 Saunders Settlement Road • Sanborn NY 14132-9460 • (716) 614-6275 phone • (716) 614-6817 fax

Name_____ Date of Birth_____ Student ID#:_____
(please print)

**New York State Public Health Law requires that ALL college and university students read the enclosed information regarding Meningitis, complete and sign this form, and return it to Niagara County Community College Wellness Center, Room C122.**

**Check One Box and Sign Below:**

**I have:**

❑ had the meningococcal meningitis immunization. **(Official Documentation REQUIRED)**

[Note: The Advisory Committee on Immunization Practices recommends that all first-year college students up to age 21 years should have at least 1 dose of Meningococcal ACWY vaccine not more than 5 years before enrollment, preferably on or after their 16th birthday, and that young adults aged 16 through 23 years may also choose to receive the Meningococcal B vaccine series. College and university students should discuss the Meningococcal B vaccine with a healthcare provider.]

**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 (my child) will **NOT** obtain immunization against meningococcal meningitis disease.

_____ _____
Student Signature (Parent/Guardian of student under 18 years of age) Date

**New York State Public Health Law requires persons born on or after January 1, 1957, to provide the following immunizations - All dates must include MONTH, DAY and YEAR. This section to be completed by health care providers in lieu of, or in addition to, an official copy of immunization records.**

**MEASLES (RUBEOLA) IMMUNITY:**

A. MMR(two doses) administered on or after first birthday and after January 1, 1972.
1. _____ 2. _____

**OR**

B. Must have **one** of the following:
1. TWO Dates of Measles Immunization *(1) _____ *(2) _____ **Both must have been given after 1/1/68 AND on, or after, first birthday.**

**OR** 2. Date of positive Measles Titer _____ Results_____ Copy of titer REQUIRED.

**OR** 3. Date and Signature of Physician that diagnosed Measles _____

**MUMPS IMMUNITY:**

Must have **one** of the following:
1. Date of ONE Mumps Immunization _____ Must have been given after 1/1/69 AND on, or after, first birthday.

**OR** 2. Date of positive of Mumps Titer _____ Results _____ Copy of titer REQUIRED.

**OR** 3. Date and Signature of Physician that diagnosed Mumps _____

**RUBELLA (GERMAN MEASLES) IMMUNITY:**

Must have **one** of the following:
1. Date of ONE Rubella Immunization_____ Must have been given after 1/1/69 AND on, or after, first birthday.

**OR** 2. Date of positive Rubella Titer _____ Results _____ Copy of titer REQUIRED.

_____ _____
Signature of Health Care Provider Required Date

_____ _____
Address Phone Number

## Health History

This page is to be filled out by the student to better assist the staff in the Wellness Center in meeting any medical needs. The information on this form is to be disclosed voluntarily, is completely confidential, and will be filed in the Wellness Center.

Name: _____ Student ID#: _____
last first middle initial

Address: _____ _____ Date of Birth: _____
street city state zip code

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

College(s)/Universities _____ Dates of attendance:_____
attended since 1990:

### EMERGENCY NOTIFICATION

Name: _____ Relationship: _____

Home Phone: (_____ ) _____ - _____ Cell: (_____) _____- _____ Office: (_____ ) _____ - _____

### PERSONAL MEDICAL HISTORY

Please x below if you have had or are currently under treatment for any of the following: (Please explain all X's marked below)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ADD | ❑ | Cerebral Palsy | ❑ | Hepatitis | ❑ | Seizures | ❑ |
| ADHD | ❑ | Chicken Pox | ❑ | High Blood Pressure | ❑ | Skin Disorders | ❑ |
| Alcoholism | ❑ | Chronic Bronchitis | ❑ | Hypoglycemia | ❑ | Substance Abuse | ❑ |
| Anemia | ❑ | Colitis/Irritable Bowel | ❑ | Kidney Disorder | ❑ | Thyroid Disease | ❑ |
| Anorexia | ❑ | Deafness | ❑ | Learning Disability | ❑ | Tuberculosis or TB Exposure | ❑ |
| Anxiety | ❑ | Depression | ❑ | Low Blood Pressure | ❑ | Whooping Cough | ❑ |
| Arthritis | ❑ | Diabetes | ❑ | Mental Health | ❑ | **FEMALES:** | |
| Asthma | ❑ | Emotional Disorder | ❑ | Migraine Headaches | ❑ | Irregular Periods | ❑ |
| Back/Spine Disorder | ❑ | Epilepsy | ❑ | Mononucleosis | ❑ | Severe Cramps | ❑ |
| Bipolar Disorder | ❑ | Fainting Spells | ❑ | Multiple Sclerosis | ❑ | Excessive Flow | ❑ |
| Bulimia | ❑ | GERD | ❑ | Orthopedic Problems | ❑ | Other _____ | |
| Cancer | ❑ | Heart Disease/Disorder | ❑ | Peptic Ulcer | ❑ | _____ | |

Explanation for any marked boxes above: _____

_____

Do you have a medical condition that impairs your vision? ❑ No ❑ Yes Do you wear glasses? ❑ No ❑ Yes
Do you wear contact lenses? ❑ No ❑ Yes Is your hearing impaired? ❑ No ❑ Yes Do you have frequent headaches? ❑ No ❑ Yes

**ALLERGIES:** (An allergy is a skin rash, hives, joint pain, swollen glands, stuffy nose and/or fever after exposure to something to which you are allergic.)
Do you have any allergies? ❑ No ❑ Yes If "YES", check items to which you are allergic
Environmental ❑ Medications ❑ Bee Stings ❑ Foods ❑ Other ❑

Explain allergy(s) _____
Do you have a LATEX allergy? ❑ No ❑ Yes If "YES", what are your symptoms?_____
Do you take an allergy vaccine or medications? ❑ No ❑ Yes If "YES", please list_____
Have you ever had surgery? ❑ No ❑ Yes if "YES", list date(s) and reason(s) _____
Have you had any serious injury? ❑ No ❑ Yes If "YES", list with dates)_____
Do you have any limitations on activities? ❑ No ❑ Yes If "YES", Explain _____

**DISABILITY:**
Do you have any physical disability? ❑ No ❑ Yes If "YES", what? _____
Do you use any device? (i.e. wheelchair, crutches, other)? ❑ No ❑ Yes If "YES", please list_____