Alfred State
SUNY College of Technology

Health and Wellness Services
TA Parish Hall • 10 Upper College Dr., Alfred, NY 14802 • 607-587-4200 Email – healthandwellness@alfredstate.edu

Health History

Due Date: June 1 for the fall semester and December 1 for the spring semester. Please submit records one time only.

1. According to NYS Health Law, all students registered for 6 or more credits must provide proof of immunity to measles, mumps & rubella and either receive or decline the meningitis vaccine. Failure to do so will result in withdrawal from class.
2. Immunization information can be obtained from the following sources: your private medical practitioner, high school health office, previous college health services (transfer students), or infant records held by parents that are signed by a physician.

Student Identification

Student ID# _____

Name _____
Last First MI

Phone _____

Birth Date ___ ___ / ___ ___ / ___ ___ ___ ___

Emergency Contact

Name _____
Last First MI

Address _____

_____

Phone _____

MANDATORY IMMUNIZATION INFORMATION – Please have your physician complete & sign below.

Students born on or after January 1, 1957 must show proof of immunity to measles, mumps and rubella.
Dates of MMR: 1. _____ 2. _____ or titers. Attach a copy of records signed by a Health Care Provider.

I certify that the above immunization record is accurate.
Provider Signature _____ **Date:** _____

ALL IMMUNIZATION RECORDS MUST BE SIGNED BY A HEALTH CARE PROVIDER

MENINGOCOCCAL MENINGITIS VACCINE – RESPONSE REQUIRED

REQUIRED —— To be COMPLETED and SIGNED by student or parent/guardian for student under the age of 18

☐ I have received the menomune vaccine within the past 10 years. Date: _____
☐ I have received the menactra vaccine within the past 10 years. Date: _____
☐ I have received the menvo vaccine within the past 10 years. Date: _____
☐ 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.

Signed: _____ **Date:** _____
(Student signature-Parent if under 18)

Please indicate if you have ever had/have the following:

Illness	Yes	No	Illness	Yes	No
1. Asthma/Hayfever			4. Seizures/Convulsions		
2. Diagnosed Depression/Anxiety/Mood Disorder/Counseling			5. Heart Murmur/Disease/Clotting Disorder		
3. Diabetes			6. Eating Disorder		
List any surgeries:					
7. List current medications:					
8. Allergies to: Food Medication Other If circled, please explain:					

Consent for Medical Care:

I hereby give permission to the Alfred State medical staff to examine and treat all medical problems/injuries while at Alfred State. In the event of time restraints, or that I cannot be reached, I hereby give permission for Health & Wellness staff to secure consultative care as needed. I understand that I have the right to revoke this consent at any time.

_____ AND _____
Student signature/Date Parent/guardian signature of a student under 18 years of age/Date