Student Health Forms
Required by New York State Law

Return By
AUGUST 1st for Fall Semester entry
JANUARY 15TH for Spring Semester entry

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

IMPORTANT
NO STUDENT WILL BE PERMITTED TO ATTEND CLASS UNTIL FORMS ARE RETURNED
YOU MUST EITHER WAIVE OR ENROLL IN COLLEGE-OFFERED HEALTH INSURANCE ONLINE; INSTRUCTIONS INSIDE

Questions?
Contact the Student Health Services Office
Susan.Crane@concordia-ny.edu
914.337.9300 x2243

Revised: NOVEMBER 2019
STUDENT ATHLETES – STOP!
This is not the Student Athlete form. Please contact the health center for the Student Athlete form.

IMPORTANT
NO STUDENT WILL BE PERMITTED TO ATTEND CLASS UNTIL FORMS ARE RETURNED
THIS FORM IS NOT VALID IF ANY INFORMATION IS MISSING
THIS FORM REQUIREs A HEALTH CARE PROVIDER’S SIGNATURE, STAMP AND LICENSE NUMBER
ALL SECTIONS ARE MANDATORY

Instructions
SECTION 1
Personal Health History and Physical Examination Form
ClinicIn’s physical examination must be dated within the last year.

SECTION 2
Measles, Mumps, & Rubella Immunizations
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 1st 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 (Rubella):** Two (2) doses are required. The first dose must have been received on or after the 1st birthday.
**Mumps:** One (1) dose is required and must have been received on or after the 1st birthday.
**Rubella (German measles):** One (1) dose is required and must have been received on or after the 1st birthday. A previous history of having Rubella is not acceptable proof of immunity.

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.
SECTION 1-A: Personal Health History (To be completed by Student)

Name: _______________________________ E-MAIL Address: _______________________________

Concordia ID # __________________________ Student Cell # __________________________

Home Address:

<table>
<thead>
<tr>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

Personal Information: Date of Birth ___________ Age: __________ Gender: Male ______ Female ______

Student Type: First-Year: ______ Transfer: ______

Housing Status: Resident ______ Commuter ______

IT IS MANDATORY THAT YOU MAINTAIN HEALTH INSURANCE EVERY YEAR THAT YOU ATTEND CONCORDIA COLLEGE NY.

WHETHER YOU ARE ENROLLING OR DECLINING THE COLLEGE PLAN, YOU MUST DO SO ONLINE – PLEASE SEE LAST PAGE FOR INSTRUCTIONS

*INTERNATIONAL STUDENTS MUST ENROLL IN THE COLLEGE-OFFERED HEALTH INSURANCE PLAN

PLEASE INCLUDE A COPY OF YOUR CURRENT INSURANCE CARD, FRONT AND BACK

Person to be notified in emergency: Name: __________________________ Relationship: __________________________

Address:

Telephone: Home: __________ Work: __________

Personal History:

Please answer all questions. Comment on all positive answers in space allowed (see next page).

Have you had:                      Yes  No                      Yes  No
Scarlet Fever                      ☐  ☐                      Thyroid Disease ☐  ☐
Measles                            ☐  ☐
German Measles                     ☐  ☐
Mumps                              ☐  ☐                      Surgery:
Chicken Pox                        ☐  ☐                      Appendectomy ☐  ☐
Malaria                            ☐  ☐                      Tonsillectomy ☐  ☐
Nose/Throat Trouble                ☐  ☐                      Hernia Repair ☐  ☐
Eye Trouble                        ☐  ☐                      Other ☐  ☐
Recurrent Colds                    ☐  ☐                      Allergies to:
Sinusitis                          ☐  ☐                      Penicillin ☐  ☐
Hay Fever                          ☐  ☐                      Sulfonamides ☐  ☐
                                            ☐  ☐                      Serum ☐  ☐
Joint Disease or Injury:           ☐  ☐                      Foods (list below) ☐  ☐
"Trick" Knee, Shoulder             ☐  ☐                      Other ☐  ☐
Back Problems                      ☐  ☐
Diarrhea/Constipation              ☐  ☐                      Females Only:
Gallbladder/Gallstones             ☐  ☐                      Irregular Periods ☐  ☐
Rupture, Hernia                    ☐  ☐                      Severe Cramps ☐  ☐
Jaundice (Liver Disease)           ☐  ☐                      Excessive Flow ☐  ☐
Stomach/Intestine Trouble          ☐  ☐                      Other ☐  ☐
Name:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th></th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Frequent Anxiety</td>
<td></td>
<td></td>
<td>Chronic Cough</td>
<td></td>
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<tr>
<td>Frequent Depression</td>
<td></td>
<td></td>
<td>Shortness of Breath</td>
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<tr>
<td>Nervousness</td>
<td></td>
<td></td>
<td>Heart Murmur</td>
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<tr>
<td>Head injury</td>
<td></td>
<td></td>
<td>Heart Palpitations</td>
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<tr>
<td><em>with Unconsciousness</em></td>
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<td></td>
<td>Rheumatic Fever</td>
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<tr>
<td>Recurrent Headaches</td>
<td></td>
<td></td>
<td>Pain/Pressure in Chest</td>
<td></td>
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<tr>
<td>Gum/Tooth Problems</td>
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<td></td>
<td>High or Low Blood Pressure</td>
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<tr>
<td>Acne</td>
<td></td>
<td></td>
<td>Diabetes</td>
<td></td>
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<tr>
<td>Epileptic Seizures</td>
<td></td>
<td></td>
<td>Frequent Urination</td>
<td></td>
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<tr>
<td>Tumor, Cancer, Cyst</td>
<td></td>
<td></td>
<td>Sexually Transmitted Disease (STD)</td>
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<tr>
<td>Dizziness, Fainting</td>
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<tr>
<td>Weakness/Paralysis</td>
<td></td>
<td></td>
<td>Recent Weight Gain or Loss</td>
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<tr>
<td>Tuberculosis</td>
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<tr>
<td>Asthma</td>
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</table>

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 take any medication at present? Yes No (If Yes, please list below)
G. Do you drink alcohol? Yes No If Yes, what type and how often?
H. Do you use recreational drugs? Yes No (If Yes, please list below)

Comments:

Family History

Among your relatives is there any history or present illness from the following: If yes, what relative?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Relative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td></td>
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<td></td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Allergy</td>
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<td></td>
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<tr>
<td>Tuberculosis</td>
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<tr>
<td>Kidney Disease</td>
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<tr>
<td>Heart disease,</td>
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<tr>
<td>high blood pressure or stroke</td>
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<tr>
<td>Convulsions</td>
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<td>Arthritis</td>
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<td></td>
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<tr>
<td>Stomach disease</td>
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<tr>
<td>Nervous difficulties</td>
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<tr>
<td>Any other disease</td>
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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 or Wellness 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 __________

Date ______________ Parent or Guardian's Signature __________________

(If under age 18 and unmarried, parent or guardian must also sign.)
Section 1-B. PHYSICAL EXAMINATION FORM (To be completed by a Health Care Provider)

Student’s Name: ___________________________ Concordia ID#: C __________

Gender (circle): M   F   Date of Birth: _________

Date of Exam: _______________ (to be completed only by MD, DO, NP or PA)

Height: _______ Weight: _______ BMI: _______ BP: _______ Pulse: _______

Vision: R 20/ __  L 20/ __

Current Medications: ____________________________________________

Allergies to Medications: _________________________________________

Type of reaction: ________________

Other Allergies: _________________________________________________

Type of reaction: ________________

<table>
<thead>
<tr>
<th>SYSTEM</th>
<th>NORMAL</th>
<th>DESCRIBE ABNORMALITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin</td>
<td></td>
<td></td>
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<tr>
<td>HEENT</td>
<td></td>
<td></td>
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<tr>
<td>Lungs/Chest</td>
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<tr>
<td>Breasts</td>
<td></td>
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<tr>
<td>Heart/Vascular System</td>
<td></td>
<td></td>
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<tr>
<td>Abdomen (rectal if indicated)</td>
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<td></td>
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<tr>
<td>Genito-urinary</td>
<td></td>
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<td>Pelvic (if indicated)</td>
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<tr>
<td>Musculoskeletal</td>
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<tr>
<td>Neurological</td>
<td></td>
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<tr>
<td>Psychological</td>
<td></td>
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<tr>
<td>Other:</td>
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Current & Chronic Problems

1. ____________________________ 2. ____________________________ 3. ____________________________

IF THE STUDENT IS UNDER CARE FOR A CHRONIC OR SERIOUS ILLNESS, PLEASE DESCRIBE BELOW AND ATTACH ADDITIONAL CLINICAL REPORTS TO ASSIST US IN PROVIDING CONTINUITY OF CARE.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

RECOMMENDATIONS FOR PHYSICAL ACTIVITY: Unlimited  Limited

(specify): ________________________________________________________________

Signature: ___________________________________________ Stamp: _______________________

(Physician, DO, NP, PA)

ADDRESS: ___________________________ PHONE: ___________________________
Varicella (chicken pox) Dose #1 ____________ Dose #2 ____________

Recommended for good health (not mandatory)

Tdap (Tetanus-Diptheria-Pertussis): Immunization booster within last 10 years
Date: _____/_____/_____

Hepatitis B Vaccine: Dose #1 _____/_____/_____ Dose #2 _____/_____/_____ Dose #3 _____/_____/_____  

Tuberculin Skin Test (PPD Only) To have been done within six (6) months prior to coming to Concordia
Date Planted: _________________________________
Date Read: _________________________________
Results in mm: _______________________________
(if chest x-ray was done, please attach a copy of the report)
SEC. 2 *MANDATORY* MEASLES, MUMPS, RUBELLA VACCINE REQUIREMENTS OR ATTACH IMMUNIZATION RECORD  *(To be completed by Health Care Provider)*

<table>
<thead>
<tr>
<th>Student’s Name:</th>
<th>Concordia ID# C</th>
<th>Phone Number: ( )</th>
<th>Date of Birth:</th>
<th>E-Mail:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Student Type:</th>
<th>First-Year</th>
<th>Sophomore</th>
<th>Junior</th>
<th>Senior</th>
<th>Transfer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Provider (please print)</td>
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<td></td>
<td></td>
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<tr>
<td>Address:</td>
<td></td>
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<tr>
<td>Phone: ( )</td>
<td>Fax: ( )</td>
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</tbody>
</table>

Provider’s Signature: ____________________________

**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)**

- _____ 1st MMR Dose (Administered after 1st birthday AND after 1/1/1972)   
  Month/Day/Year
  _____ / _____ / _____
  
- AND
  _____ 2nd MMR Dose (Administered after 15 months of age and at least 28 days after 1st dose)
  Month/Day/Year
  _____ / _____ / _____

**Section B1. Measles**

- _____ 1st Live Virus Dose (Administered after 1st birthday & 1/1/69)   
  Month/Day/Year
  _____ / _____ / _____
  
- AND
  _____ 2nd Live Virus Dose (Administered after 15 months of age and at least 28 days after 1st dose)
  Month/Day/Year
  _____ / _____ / _____

  OR
  _____ History of Illness (documented with statement by diagnosing provider)

  OR _____ Immunity (Proven by Serologic Testing – attach labs)

**Section B2. Mumps**

- _____ 1st Live Virus Dose (Administered after 1st birthday & 1/1/69)   
  Month/Day/Year
  _____ / _____ / _____

  OR
  _____ Immunity (Proven by Serologic Testing -attach labs)

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

- _____ Live Virus Dose (Administered after 1st birthday & 1/1/69)   
  Month/Day/Year
  _____ / _____ / _____

  OR
  _____ Immunity (Proven by Serologic Testing-attach labs)

*Note: History of Illness is NOT acceptable*
Sec. 3. Meningococcal Meningitis Vaccination Response Form
(To be completed by Health Care Provider)

A. Meningococcal Meningitis Vaccine (Menactra™/Menomune™): 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.** If you are under the age of 18, a parent or legal guardian must sign this waiver for you.

**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 a cost of $125. 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

**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:

<table>
<thead>
<tr>
<th>Date:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Month</strong> / <strong>Day</strong> / <strong>Year</strong></td>
<td><strong>Month</strong> / <strong>Day</strong> / <strong>Year</strong></td>
</tr>
</tbody>
</table>

**NOTE:** IT IS STRONGLY RECOMMENDED THAT A 2ND DOSE OF MENINGITIS VACCINE BE ADMINISTERED TO ALL ADOLESCENTS WHO RECEIVED THE FIRST DOSE PRIOR TO AGE 16. PLEASE ALSO ASK YOUR PROVIDER ABOUT THE MENINGITIS B VACCINE.

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

<table>
<thead>
<tr>
<th>Clinician Signature</th>
<th>Date</th>
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</table>

**OR**

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<thead>
<tr>
<th>Name/License#/Office Stamp</th>
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</table>

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 my child/I will not obtain immunization against meningococcal meningitis disease.

Signature of Student and/or Parent/Guardian (If student is under 18)

_________________________________________________________________________ Date: __________
WAIVE OR ENROLL IN COLLEGE-OFFERED HEALTH INSURANCE

Your bill reflects a charge for the College-offered health insurance. If you are a domestic student and covered by your family’s plan or another plan, you may decline the College-offered Health Insurance online at the website below.

IMPORTANT
INTERNATIONAL STUDENTS ARE REQUIRED TO ENROLL IN THE COLLEGE-OFFERED HEALTH INSURANCE
IF YOU HAVE OUT-OF-STATE MEDICAID, PLEASE CONTACT THE STUDENT HEALTH CENTER

www.gallagherstudent.com/concordiany
1. On the top right corner of the screen, click ‘Student Login’ and log in.
2. On the left toolbar, click ‘Student Waive/Enroll’.
3. Choose to waive or enroll. Follow the instructions to complete the form.
4. Print or write down your reference number.
5. If you choose to enroll, you will receive an enrollment packet with instructions for enrolling. The charge on your bill does not indicate enrollment; please follow the instructions in your enrollment packet.

PLEASE ATTACH A COPY OF YOUR VALID HEALTH INSURANCE CARD, FRONT AND BACK