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 Genesee Community College Health Center, Room B-109.

Check One Box and Sign Below:
I have:
☐ had the meningococcal meningitis immunization. (Official Documentation Required) Type of vaccine: _______________________

Date __________________ Health Care Provider Signature ______________________

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, a 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 __________________ OR

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 in any medical needs. Please answer the following questions as accurately as possible. (Please Print)

NAME: ___________________________ STUDENT ID#: ___________________________

ADDRESS: ___________________________ DATE OF BIRTH: ___________________________

HOME PHONE: (____) ____________________ CELL PHONE: (____) ____________________

PRIMARY PHYSICIAN: ___________________________ PHONE: (____) ____________________

EMERGENCY NOTIFICATION

NAME: ___________________________ RELATIONSHIP: ___________________________

HOME PHONE: (____) ____________________ CELL: (____) ____________________ OFFICE: (____) ____________________

COLLEGES/UNIVERSITIES ATTENDED SINCE 1990 DATES ATTENDED: ___________________________

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)

<table>
<thead>
<tr>
<th>ADD</th>
<th>ADHD</th>
<th>Alcoholism</th>
<th>Anemia</th>
<th>Anorexia</th>
<th>Anxiety</th>
<th>Arthritis</th>
<th>Asthma</th>
<th>Back/Spine Disorder</th>
<th>Bipolar Disorder</th>
<th>Bulimia</th>
<th>Cancer</th>
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</table>

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 so, 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