ADELPHI UNIVERSITY
NEW YORK

Part D

MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE FORM

Family name/surname _____ First/given name _____ MI _____

Adelphi ID no. or SSN _____ Date of birth _____

New York State Public Health Law 2167 requires that all college and university students enrolled for at least 6 semester credits, or the equivalent per semester, must complete and return the following form to the Adelphi University Health Services Center. For information regarding meningococcal disease and the meningococcal vaccination, visit **adelphi.edu/meningitis**.

Please check one of the following boxes and sign below:

I have/my child has (for students under the age of 18):

☐ Had the meningococcal meningitis immunization within the past five years.
Date received _____ Healthcare provider stamp required _____

☐ 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.

_____

Signature of student (if 18 or older/parent or guardian if student is a minor) Date

This form must be returned to the Adelphi University Health Services Center, Waldo Hall, One South Avenue, P.O. Box 701, Garden City, NY 11530-0701, USA, or faxed to 516.877.6008.

The form may be uploaded to the Health Portal in your eCampus account.

The above requirements must be submitted prior to the first day of classes.
Failure to comply will result in medical suspension from classes and subsequent withdrawal from the University.

Revised September 2022

10/22-23193

ADELPHI UNIVERSITY
NEW YORK

Part A

COMPLETE HEALTH HISTORY AND PHYSICAL EXAMINATION FORM

PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS.

THIS FORM MUST BE COMPLETED AND SUBMITTED TO THE HEALTH SERVICES CENTER PRIOR TO THE FIRST DAY OF CLASSES.

REQUIRED IMMUNIZATIONS

*New York State Public Health Law 2165 requires that students enrolled for at least 6 credits and born on or after January 1, 1957, must submit proof of immunization to measles, mumps and rubella (German measles). New York State Public Health Law 2167 requires that students enrolled for at least 6 credits also complete the meningitis vaccination response form. To learn more about meningitis vaccination, visit **adelphi.edu/health-insurance**.*

*The above requirements **must be submitted prior to the first day of classes**. Failure to comply will result in medical suspension from classes and subsequent withdrawal from the University. Students who require a medical or religious exemption must contact the Health Services Center at **516.877.6000** to discuss further requirements.*

PLEASE PRINT. (All information is required and all entries must be in English.)

Family name/surname _____ First/given name _____ MI _____

Address _____
Street Apt. City State Postal code

Adelphi ID no. or SSN _____ Date of birth _____

Home phone ( ) _____ Cellphone ( ) _____

Email _____

EMERGENCY CONTACT

Name _____ Relationship _____

Home phone ( ) _____ Cell/work phone ( ) _____

Please note, unless otherwise advised by your department, that graduate students are required, prior to the first day of class, to complete Sections A, B and D only, unless they are international or resident students, in which case all four sections are required to be completed.

Each student should have a copy of his or her insurance card at all times.
Health insurance is mandatory for all resident and international students. To learn about the requirements and waiver process, visit **gallagherstudent.com/adelphi**.

CONSENT FOR MEDICAL TREATMENT OF MINORS (students under the age of 18):
To provide medical evaluation or treatment to students under the age of 18, parental permission is necessary by law. All students younger than 18 years old require a parent's or guardian's signature submitted to the Health Services Center for medical treatment consent.

I hereby grant permission for medical evaluation, treatment and hospitalization in case of accident or illness for my minor child/legal ward. I also give permission for the release of information concerning his or her medical condition to other responsible University officials when necessary, or to outside agencies for treatment on an as-needed basis.

_____

Signature of parent/guardian Date

ADELPHI UNIVERSITY
NEW YORK

Part B

IMMUNIZATION RECORD

Immunization records are required prior to the first day of class.
Please complete this form and return it to the Health Services Center or
*fax it to **516.877.6008**. If any portion of this document is illegible, it will not be processed.*
Healthcare provider's stamp or license number is required or it will NOT be processed.

Student name _____
Family name/surname First/given name MI

Date of birth _____ Age _____ Adelphi ID no. or SSN _____

To comply with New York state immunization law, you must have some combination equivalent to two doses of the measles vaccine, at least one mumps and one rubella, or provide serological evidence of immunity (titers).

REQUIRED IMMUNIZATIONS (to be completed by a healthcare provider)

MMR (measles, mumps, rubella)—If given as a combined dose instead of individual immunizations
☐ Dose 1: Immunized no more than four days prior to first birthday and after 1971 Date ____/____/____
☐ Dose 2: Immunized as above and at least 28 days after first dose of MMR Date ____/____/____

Or

MEASLES—Two doses at least 28 days apart, given no more than four days prior to first birthday and after 1967
☐ Dose 1: Immunized on or after January 1, 1968 Date ____/____/____
☐ Dose 2: Immunized as above and at least 28 days after first dose of measles Date ____/____/____
MUMPS—One dose after January 1, 1968 Date ____/____/____
RUBELLA (German measles)—One dose after January 1, 1968 Date ____/____/____

Or

Serologic evidence of immunity for each disease—Laboratory reports verifying immunity (IgG) to measles, mumps and rubella are required (titers).
☐ Lab reports attached

RECOMMENDED IMMUNIZATIONS

COVID-19 vaccine 1) __/__/___ 2) __/__/___ Booster ____/____/____

Tdap (booster recommended for all students) ____/____/____ Meningococcal Type B vaccine date ____/____/____

Meningococcal Type ACYW-135 date ____/____/____
(must also complete under Part D)

Or

Tetanus toxoid (within 10 years) ____/____/____

Chicken pox (varicella) immunization 1) ____/____/____ 2) ____/____/____

Hepatitis B series 1) ____/____/____ 2)____/____/____ 3)____/____/____

Hepatitis A series 1) ____/____/____ 2)____/____/____ (if considering or definitely traveling abroad)

Gardasil series 1) ____/____/____ 2) ____/____/____ 3) ____/____/____

Note: If student is a nursing major, serological evidence of immunity (titers) to measles, mumps, rubella, varicella and hepatitis B will be required for clinical rotations, and may be required for COVID-19.

Healthcare Provider (Official stamp is required; no form will be accepted without stamp, or license number if no stamp available.)

Name _____ Phone _____

Signature _____ License no. _____

Date _____ Stamp

Part C

Family name/surname _____ First/given name _____ MI _____

Adelphi ID no. or SSN _____ Date of birth _____ Age _____

SECTION 1 (Student must complete this part prior to exam.)

Drug allergies _____ Food allergies or intolerance _____

Does student require EpiPen? ☐ Yes ☐ No Has student been trained in its use? ☐ Yes ☐ No

Medications (Please include prescription medications and any over-the-counter medications taken daily.)

_____

Past medical history _____

_____

Family medical history _____

_____

SECTION 2: HEALTHCARE PROVIDER'S EXAMINATION (to be completed by provider only)

Height _____ Weight _____ BMI _____ Blood pressure _____ Heart rate _____

Vision R _____ L _____ (corrected or uncorrected) Hearing _____ (whisper acceptable)

System	Satisfactory	Unsatisfactory	Details, if Unsatisfactory
HEENT			
Respiratory			
Cardiovascular			
Abdominal			
Genitourinary			
Musculoskeletal			
Skin			
Neurovascular			

Tuberculosis Testing: This is mandatory for all international students and students entering into health-related clinical sites or student teaching. For international students or those who may have received BCG vaccine, the T-Spot.TB (preferred) or QuantiFERON blood test is required. (A copy of the lab test is required.)

TST (PPD): Date placed _____ R or L forearm (Circle one.) Date read _____ Result in mm (Must be written): _____

Is the PPD positive or negative? (Circle one.) If positive, must have chest X-ray with CXR result attached.

T-Spot.TB or QuantiFERON result: _____ (If these tests are done, a copy of the lab test must be included with this paperwork.)

All positive tests require a chest X-ray within the last five years and a copy of the X-ray results must be included.

Student is cleared for all physical activities and/or athletic activities. Yes No

If no, please explain why. _____
(If this response is not completed, student will not be allowed to participate in any physical education classes or athletic activities.)

Healthcare provider's name _____ Date of exam _____

Signature _____ License no. _____ Phone _____

This form will not be accepted without date and healthcare provider's signature and stamp, or license number if no stamp available.