NIAGARA UNIVERSITY

NEW STUDENT IMMUNIZATION & PHYSICAL FORM

All undergraduate, transfer, and international, and Canadian students must complete and submit this form to Student Health Services.
Minor students must have a parent or guardian complete the form.
If attending in fall form is due July 31
If attending in spring form is due January 1
Incomplete or overdue forms will delay or cancel registration and prevent sports participation.

Physical examinations must be done within 12 months of attendance.
For intercollegiate Division 1 athletes, physical examinations must be done within 6 months for sports participation.

Mail form to: STUDENT HEALTH SERVICES
Butler Building PO Box 1923
Niagara University, NY 14109-1923
Fax form to: 716.286.8391
Phone: 716.286.8390

LAST NAME | FIRST NAME | MIDDLE INITIAL | COLLEGE ID / MEDICAT ID

DATE OF BIRTH (MM/DD/YYYY) | GENDER | EMAIL ADDRESS

PERMANENT ADDRESS | CITY | STATE | ZIP CODE

HOME PHONE | CELL PHONE | CITIZENSHIP

EMERGENCY CONTACT - This is the person we will contact in the event you have a medical emergency at school.

EMERGENCY CONTACT - NAME/RELATIONSHIP | HOME PHONE | CELL PHONE | WORK PHONE

EMERGENCY CONTACT - ADDRESS | CITY | COUNTRY | POSTAL CODE | EMAIL ADDRESS

PERSONAL PHYSICIAN

PERSONAL PRIMARY PHYSICIAN | ADDRESS | PHONE | FAX

HEALTH INSURANCE: PLEASE CARRY YOUR HEALTH INSURANCE CARD WHILE ON CAMPUS.

CONSENT TO TREAT, ATTESTATION, AUTHORIZATION FOR MYNIAGARA HEALTH PORTAL

Without signature Student Health Services cannot treat this student. Parent or Guardian must sign for student under 18 years of age.

I authorize the I authorize the Niagara University's Student Health Services to provide care and treatment to me (my child/legal ward) as deemed appropriate. This includes but is not limited to routine, urgent, emergency care, medication, immunization, diagnostic studies and referrals to hospitals, clinics and/or medical specialists deemed necessary by the college's medical and/or nursing staff. In the event of a life threatening emergency or serious illness/injury of which the Student Health Services is aware, I authorize the Student Health Services or college designee to notify my emergency contact. I verify that all medical and psychological information I have provided is complete and accurate. I will notify the Student Health Services hereafter of any changes in my health that occur while a student at Niagara University. I authorize Student Health Services to communicate with me using my secure health portal, myNuHealth. This communication may include but is not limited to lab results, clinical notes and additional medical recommendations for my ongoing care and treatment each semester I am a registered student at the college. Access to myNuHealth is limited to the current semester enrolled.

SIGNATURE OF STUDENT (REQUIRED) **DATE (MM/DD/YY)**

SIGNATURE OF PARENT/GUARDIAN FOR MINOR (REQUIRED) **DATE (MM/DD/YY)**

Revised 2-3-2023

NIAGARA UNIVERSITY

MEDICAL HISTORY

NAME OF STUDENT DATE OF BIRTH (MM/DD/YYYY) COLLEGE ID #

Please check box if you have ever had any of the following conditions.

INFECTIOUS DISEASE
- ☐ Chicken Pox
- ☐ Infectious Mononucleosis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Tuberculosis
- ☐ Malaria

EYES, EARS, NOSE, THROAT
- ☐ Wear Glasses/Contact
- ☐ Other Visual Problems
- ☐ Hearing Loss/Deafness
- ☐ Seasonal Allergies
- ☐ Recurrent Sinus Infection
- ☐ Recurrent Ear Infection
- ☐ Recurrent Nose Bleeds

CARDIOPULMONARY
- ☐ Chest Pain with Exercise or Exertion
- ☐ Syncope or Near Syncope
- ☐ Excessive Exertional or Unexplained Shortness of Breath with Exercise
- ☐ Excessive Exertional or Unexplained Fatigue with Exercise
- ☐ Heart Murmur
- ☐ Elevated Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Rheumatic Heart Disease
- ☐ Heart Palpitations or Irregular beat
- ☐ Elevated Cholesterol
- ☐ Marfan syndrome
- ☐ Congenital Heart Defect
- ☐ Asthma
- ☐ Pneumonia/Bronchitis

G-I
- ☐ Reflux/GERD
- ☐ Ulcer
- ☐ Pancreatitis
- ☐ Gall Bladder Disease
- ☐ Hepatitis Type: _____
- ☐ Hernia
- ☐ Rectal Bleeding
- ☐ Irritable Bowel
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Hemorrhoids

GENITOURINARY
- ☐ Cystitis/Bladder Infection
- ☐ Blood in Urine
- ☐ Kidney Infection
- ☐ Chronic Kidney Disease
- ☐ Kidney Stones
- ☐ Sexually Transmitted Infection

FEMALE
- ☐ Pelvic/Vaginal Infections
- ☐ Pregnancy
- ☐ Breast Lump
- ☐ Painful Periods
- ☐ Irregular Periods
- ☐ Heavy Flow
- ☐ Abnormal Pap smear

MALE
- ☐ Testicular Lump
- ☐ Testicular Torsion
- ☐ Undescended/Absent Testicle
- ☐ Hydrocele or Varicocele

MUSCULOSKELETAL
- ☐ Arthritis
- ☐ Joint Injury
- ☐ Bone Fractures
- ☐ Scoliosis
- ☐ Back Pain/Problems
- ☐ Osgood-Schlatter
- ☐ Tendinitis
- ☐ Other Musculoskeletal Disorders

HEMATOLOGIC/ONCOLOGIC
- ☐ Anemia
- ☐ Sickle Cell Trait/Disease
- ☐ Leukemia/Lymphoma
- ☐ Hemophilia
- ☐ Immune Deficiency
- ☐ Cancer

NEUROLOGIC
- ☐ ADD/ADHD
- ☐ Seizure Disorder
- ☐ Migraine Headaches
- ☐ Tension Headaches
- ☐ Concussion
- ☐ Head Injury with Loss of Consciousness
- ☐ Other Neurological Disorders

SKIN
- ☐ Eczema
- ☐ Acne
- ☐ Hives
- ☐ Chronic Rash
- ☐ Tattoos/Piercings
- ☐ Other: _____

METABOLIC
- ☐ Diabetes Mellitus
- ☐ Thyroid Disorder

MENTAL/EMOTIONAL
- ☐ Anger Management
- ☐ Eating Disorder
- ☐ Drug/Alcohol Dependency/Abuse
- ☐ Depression
- ☐ Panic/Anxiety Disorder
- ☐ Trouble Sleeping
- ☐ Bipolar Disorder
- ☐ Mood Disorder
- ☐ Obsessive Compulsive Disorder
- ☐ Schizophrenia
- ☐ Deliberate Self Harm
- ☐ Previous Psychiatric Hospitalization
- ☐ Other: _____

OTHER
- ☐ Anaphylactic Reaction
- ☐ Serious Accident/Injury
- ☐ Loss of Paired Organ:
  - ☐ Kidney
  - ☐ Ovary
  - ☐ Eye
  - ☐ Testicle
  - ☐ Other: _____
- ☐ Other Important Medical History:

_____

Do you use tobacco?
☐ No ☐ Yes – packs/day _____

Do you drink alcohol?
☐ No ☐ Yes – amount/week _____

ALLERGIES: ☐ None
- ☐ Allergic to medications
- ☐ Allergic to X-ray dyes
- ☐ Allergic to food/insects/ environmental

Please list all

_____

_____

SURGERIES: ☐ None
- ☐ Appendectomy
- ☐ Hernia repair
- ☐ Mole Removal
- ☐ Ear Tubes
- ☐ Wisdom Teeth Extraction
- ☐ Tonsils/Adenoids

Other: (specify below)

_____

MEDICATIONS: (including vitamins and supplements):
☐ None

_____

_____

_____

_____

Additional information you wish to share about your health:

_____

_____

_____

_____

FAMILY HISTORY

	Age	If Deceased, State of Health	Age of Death	Cause of Death
Father				
Mother				
Siblings				

Have any of your relatives ever had any of the following?	Yes	Relationship		Yes	Relationship
Alcoholism			Cancer		
Asthma, Hay Fever			Mental Illness		
Diabetes			Kidney Disease		
Sickle Cell Trait/Disease			Seizure Disorder		
Disability due to heart disease before age 50			Marfan syndrome		
Elevated Blood Pressure			Other (list):		
Other heart related diagnosis, cardiomyopathies, long QT syndrome, arrhythmias					

Revised 2-3-2023

NIAGARA UNIVERSITY

PHYSICAL EXAMINATION

TO BE COMPLETED, SIGNED AND DATED BY HEALTHCARE PROVIDER

NAME | DATE OF BIRTH (MM/DD/YYYY) | GENDER

HEIGHT | WEIGHT | BLOOD PRESSURE | PULSE

SICKLE CELL SCREEN- Required for all D1 athelets Sickle Cell Screen Date: Month_____ Day_____ Year_____

Positive Negative

TUBERCULOSIS (TB) SCREEN - Required for all students. CIRCLE CORRECT ANSWER

1. Does the student have signs or symptoms of active TB disease **YES** (go to TB Test) **NO** (go to question 2)
2. Is the student a member of a high risk group, or from a high risk country? **YES** (go to TB Test) **NO** (**STOP** No further screening needed)

TUBERCULIN SKIN TEST: (Mantoux only)

Date placed:___/___/___ (MM/DD/YY) Date read:___/___/___ (MM/DD/YY)

Result:____mm of induration

Interpretation based on mm of induration and risk factors:

Negative Positive (Chest X-ray required)

TB SKIN TEST OR TB BLOOD TEST

IGRA: (Specify method) QFT-G QFT-GIT T-SPOT

SPOT Date Tested:___/___/_____ (MM/DD/YY)

Result: Negative
Indeterminate/Borderline (repeat in 6-8 weeks)
Positive (Chest X-Ray required)

Chest X-Ray Date: ___/___/___ (MM/DD/YY) Result: Normal Abnormal (explain):_____

Treatment Plan (include information about INH therapy and duration of treatment**):** _____

CLINICAL EVALUATION	NORMAL	RECORD ABNORMAL FINDINGS
1. Appearance (Report evidence of Marfan Stigmata)		
2. Skin		
3. Head, Ears, Eyes, Nose, Hearing, Visual Acuity		
4. Mouth, Teeth, Gums		
5. Neck and Thyroid		
6. Lungs/Chest		
7. Breasts		
8. Heart (supine and standing)		
9. Pulses (simultaneous femoral and radial)		
10. Abdomen		
11. Genitalia		
12. Back/Spine		
13. Extremities/Musculoskeletal		
14. Neurologic		
15. Emotional/Psychological		
16. Paired Organ Anatomy/Function		

17. **ACTIVITY CLEARANCE**

Is this student cleared for full physical activity, including participation in intramural, club or intercollegiate sports and able to meet the physical and emotional demands of college life, including studying abroad?

YES - Full activity and fit for college **NO** - Limited activity Reason:_____

18. Additional Comments/Recommendations:_____

HEALTH CARE PROVIDER SIGNATURE **HEALTHCARE PROVIDER PRINTED NAME** **DATE**

ADDRESS **PHONE**

Revised 2-3-2023

NIAGARA UNIVERSITY

IMMUNIZATION FORM

TO BE COMPLETED, SIGNED AND DATED BY HEALTHCARE PROVIDER

NAME OF STUDENT **DATE OF BIRTH (MM/DD/YYYY)** **COLLEGE ID #**

REQUIRED IMMUNIZATIONS

VACCINE	DATE MM/DD/YYYY	DATE MM/DD/YYYY	DATE OF POSITIVE LAB/SEROLOGIC EVIDENCE	
MMR (Required if born after 1957 or positive titer)	12 months or older / /	Minimum 1 month after 1st dose / /		For information about the MMR vaccine in other languages, please go to: www.immunize.org/vis/vis_mmr.asp
Measles	/ /	/ /	□Copy of report required	
Mumps	/ /	/ /	□Copy of report required	
Rubella	/ /	/ /	□Copy of report required	
Meningococcal ACWY or NU Menigitis Declination	□Menactra □Menveo / /	Booster required if given before age 16 / /	Booster type: □ Menactra □ Menveo	For information about the Meningococcal vaccine in other languages, go to: www.immunize.org/vis/vis_meningococcal_acwy.asp

****NURSING STUDENTS ONLY****
MUST FULFILL ADDITIONAL IMMUNIZATION REQUIREMENTS AS NOTED BELOW.
IMMUNIZATIONS CAN CHANGE ACCORDING TO CLINICAL SITE GUIDELINES.
CONTACT THE SCHOOL OF NURSING FOR ADDITIONAL INFORMATION.

RECOMMENDED IMMUNIZATIONS

VACCINE	DATE MM/DD/YYYY	DATE MM/DD/YYYY	DATE MM/DD/YYYY	DATE OF POSITIVE LAB/SEROLOGIC EVIDENCE	
Tdap/Tetanus (Required within the last 10 years of arrival to the University)	□ Adecel / / □Boostrix				For information about the TDAP vaccine in other languages, please go to: www.immunize.org/vis/vis_tdap.asp
Hepatitis B	/ /	/ /	/ /	□Copy of report attached	For more information about the Hepatitis B vaccine in other languages, please go to: www.immunize.org/vis/vis_hepatitis_b.asp
Varicella	/ /	/ /		□Copy of report attached	For more information about the Varicella vaccine in other languages, please go to: www.immunize.org/vis/vis_chickenpox.asp
Meningococcal B	/ /	/ /		□Bexsero	For more information about Meningococcal B vaccine in other languages, please go to: www.immunize.org/vis/vis_meningococcal_b.asp
	/ /	/ /	/ /	□Trumenba	
COVID-19	/ /	/ /	□Pfizer □Moderna □Janssen		

NEW YORK STATE LAW:
Health care provider complete and sign the immunization section. Immunization records attached to this form must be signed or stamped.

Name_____ Signature_____

Address_____ Phone_____

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NIAGARA UNIVERSITY

NU TUBERCULOSIS (TB) RISK QUESTIONNAIRE

NAME OF STUDENT **DATE OF BIRTH (MM/DD/YYYY)** **COLLEGE ID #**

Please answer the following questions:

Have you ever had close contact with persons known or suspected to have active TB disease? **Yes** ☐ **No** ☐
Were you born in one of the countries listed below that have a high incidence of active TB disease? **Yes** ☐ **No** ☐

If yes, please circle the country below:

Angola	China	Kenya	Namibia	Tajikistan
Azerbaijan	Congo	Korea, Peoples	Nigeria	Tanzania, United
Bangladesh	Democratic	Rep. of	Pakistan	Rep. of
Belarus	Republic of the	Kyrgyzstan	Papua New Guinea	Thailand
Botswana	Congo	Lesotho	Peru	Uganda
Brazil	Ethiopia	Liberia	Philippines	Ukraine
Cambodia	Ghana	Malawi	Russian Federation	Uzbekistan
Cameroon	Guinea-Bissau	Moldova, Republic	Sierra Leone	Viet Nam
Central African	India	of	Somalia	Zambia
Republic	Indonesia	Mozambique	South Africa	Zimbabwe
Chad	IKazakhstan	Myanmar (Burma)	Swaziland	

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2010. Countries with incidence rates of >20 cases per 100,000 popultion. For future updates, refer to http://apps.who.int/ghodata

Have you had frequent or prolonged visits* to one or more of the countries listed above with a high Prevalence of TB disease? (If yes, CHECK the countries, above) **Yes** ☐ **No** ☐

Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, Long-term care facilities, and homeless shelters)? **Yes** ☐ **No** ☐

Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease? **Yes** ☐ **No** ☐

Have you ever been a member of any of the following groups that may have an increased incidence of latent *M. tuberculosis* infection or active TB disease – medically underserved, low-income, or abusing drugs or alcohol? **Yes** ☐ **No** ☐

If the answer is **YES** to any of the above questions, Niagara University requires that you receive TB testing as soon as possible but at least prior to the start of the subsequent semester.

If the answer to all the above questions is **NO**, no further testing or further action is required.

_____ _____
Student/Parent or Guardian of a Minor Student Date

_____
Do not write below this line. This form will be reviewed by NU Staff when submitted to Student Health.

_____ _____
Review Date

*Prolonged visits means living with families, close contact with local people for extended periods of time.

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NIAGARA UNIVERSITY

NU MENINGITIS DECLINATION

NAME OF STUDENT **DATE OF BIRTH (MM/DD/YYYY)** **COLLEGE ID #**

WHAT IS MENINGOCOCCAL DISEASE?
Meningococcal disease is caused by bacteria called Neisseria meningitidis. It can lead to serious blood infections. When the linings of the brain and spinal cord become inflamed, it is called meningitis. The disease strikes quickly and can have serious complications, including death.

WHO GETS MEINGOCOCCAL DISEASE?
Anyone can get meningococcal disease. Some people are at higher risk. This disease occurs more often in people who are:

- Teenagers or young adults
- Infants younger than one year of age
- Living in crowded settings, such as college dormitories or military barracks
- Traveling to areas outside of the United States, such as the "meningitis belt" in Africa
- Living with a damaged spleen or no spleen
- Being treated with Soliris® or, who have complement component deficiency (an inherited immune disorder)
- Exposed during an outbreak
- Working with meningococcal bacteria in a laboratory

WHAT ARE THE SYMPTOMS? Symptoms appear suddenly – usually 3 to 4 days after a person is infected. It can take up to 10 days to develop symptoms. Symptoms may include:

- A sudden high fever
- Headache
- Stiff neck (meningitis)
- Nausea and vomiting
- Red-purple skin rash
- Weakness and feeling very ill
- Eyes sensitive to light

HOW IS MENINGOCOCCAL DISEASE SPREAD?
It spreads from person-to-person by coughing or coming into close or lengthy contact with someone who is sick or who carries the bacteria. Contact includes kissing, sharing drinks, or living together. Up to one in 10 people carry meningococcal bacteria in their nose or throat without getting sick.

IS THERE TREATMENT?
Early diagnosis of meningococcal disease is very important. If it is caught early, meningococcal disease can be treated with antibiotics. But, sometimes the infection has caused too much damage for antibiotics to prevent death or serious long-term problems. Most people need to be cared for in a hospital due to serious, life-threatening infections.

WHAT ARE THE COMPLICATIONS?
Ten to 15 percent of those who get meningococcal disease die. Among survivors, as many as one in five will have permanent disabilities. Complications include: Hearing loss, brain damage, kidney damage and/or limb amputation.

WHAT SHOULD I DO IF I OR SOMEONE I LOVE IS EXPOSED?
If you are in close contact with a person with meningococcal disease, talk with your health care provider about the risk to you and your family. They can prescribe an antibiotic to prevent the disease.

WHAT IS THE BEST WAY TO PREVENT MENINGOCOCCAL DISEASE?
The single best way to prevent this disease is to be vaccinated. Vaccines are available for people 6 weeks of age and older.
Various vaccines offer protection against the five major strains of bacteria that cause meningococcal disease:

- All teenagers should receive two doses of vaccine against strains A, C, W and Y. The first dose is given at 11 to 12 years of age, and the second dose (booster) at age 16.
- It is important that teens receive the booster dose at age 16 in order to protect them through the years when they are at greatest risk of meningococcal disease.
- Talk to your health care provider today if your teen has not received two doses of vaccine against meningococcal strains A, C, W and Y.
- College students can also be vaccinated against the "B" strain. Talk to your health care provider about whether they recommend vaccine against the "B" strain.

Others who should receive the vaccine include:

- Infants, children and adults with certain medical conditions
- People exposed during an outbreak
- Travelers to the "meningitis belt" of sub-Saharan Africa
- Military recruits

IS THERE AN INCREASED RISK FOR MENINGOCOCCAL DISEASE IF I TRAVEL?
Meningococcal disease and outbreaks occur in the United States and around the world. The disease is more common in the "meningitis belt" of sub-Saharan Africa. The risk is highest in people who visit these countries and who have prolonged contact with local populations during an epidemic. To reduce your risk of illness, wash your hands often, maintain healthy habits such as getting plenty of rest and try not to come into contact with people who are sick.

HOW DO I GET MORE INFORMATION ABOUT MENINGOCOCCAL DISEASE AND VACCINATION?
www.cdc.gov/meningococcal/ OR www.health.ny.gov/prevention/immunization/

I have read or have had explained to me, the information regarding meningococcal meningitis. I understand the risks of not receiving the vaccine. I have decided that I (my child) will NOT obtain immunization against meningococcal disease.

_____
SIGNATURE DATE

_____
PARENT SIGNATURE IF UNDER 18 DATE

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