NIAGARA UNIVERSITY
Office of Health Services

NEW STUDENT HEALTH FORMS

All Undergraduate, Transfer, and International (including Canadian) students must complete and submit this form to Student Health Services. **Students under 18 years of age must have a parent/legal guardian complete and sign this form.**
*Incomplete or overdue forms may result in a hold on the student account and possible de-registration in accordance with New York State Public Health Law. *

DEADLINES:
Fall Enrollment: August 1

Spring Enrollment: January 1

Mail to: Health Services Butler Building, PO Box 1923 Niagara University, NY 14109 **Fax:** 716-286-8391

Last Name _____ First Name _____ MI ____

NU Student ID _____ DOB _____ Gender_____

Email _____

Address _____ City_____ State_____ Zip_____

Home Phone _____ Cell Phone _____

EMERGENCY CONTACT

Name _____ Relationship _____

Home Phone _____ Cell _____ Work _____

Address_____ City_____ State_____ Zip Code _____

PERSONAL PHYSICIAN

Physician Name _____Phone_____ Fax_____

CONSENT TO TREAT, ATTESTATION, AND AUTHORIZATION

Parent/Guardian signature required for students under age 18.

I authorize Niagara University Student Health Services to provide appropriate care and treatment to the student named above, including routine, urgent, and emergency care, immunizations, diagnostic studies, and referrals to hospitals, urgent care centers, clinics, and specialists as deemed necessary by University medical staff.

Parent/Guardian Signature (if under 18) _____ **Date** _____

Printed name _____

In the event of a life-threatening emergency, I authorize Student Health Services or a University designee to notify my emergency contact.

I certify that the medical and psychological information provided is complete and accurate and that I will notify Student Health Services of any changes while enrolled at Niagara University.

Student Signature _____ **Date** _____

NIAGARA UNIVERSITY
Office of Health Services

MEDICAL HISTORY

Student Name: _____ Student ID: _____ DOB: _____

Please check any condition(s) you have ever had or currently have.

INFECTIOUS DISEASE
☐ Infectious Mononucleosis
☐ Tuberculosis
☐ Malaria

METABOLIC
☐ Diabetes
☐ Thyroid Disorder

GASTROINTESTINAL
☐ GERD
☐ Ulcer
☐ Pancreatitis
☐ Gallbladder Disease
☐ Hepatitis
☐ Hernia
☐ Crohn's Disease
☐ Hemorrhoids

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

MENTAL/EMOTIONAL
☐ Anger Management
☐ Eating Disorder
☐ Drug/Alcohol Abuse
☐ Depression
☐ Anxiety
☐ Panic Disorder
☐ Bipolar Disorder
☐ Psychiatric Hospitalization
☐ Mood Disorder
☐ Schizophrenia
☐ Self-Harm
☐ Other

EYES, EARS, NOSE & THROAT
☐ Wear Glasses/Contacts
☐ Hearing Loss/Deafness
☐ Seasonal Allergies

SKIN
☐ Hives
☐ Chronic Rash
☐ Eczema
☐ Tattoos/Piercings

GENITOURINARY
☐ Bladder Infection
☐ Blood in Urine
☐ Kidney Infection
☐ chronic kidney disease
☐ Kidney Stones
☐ Sexually Transmitted Infection

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

NEUROLOGIC
☐ ADD/ADHD
☐ Seizure Disorder
☐ Migraines
☐ Concussion
☐ LOC Head Injury

CARDIOPULMONARY
☐ Asthma
☐ Chest Pain
☐ Syncope
☐ SOB
☐ Heart Murmur
☐ Elevated BP
☐ Palpitations
☐ Congenital Heart Defect
☐ Pneumonia/Bronchitis

MUSCULOSKELETAL
☐ Arthritis
☐ Joint Injury
☐ Bone Fractures
☐ Scoliosis
☐ Back Pain
☐ Tendonitis

MALE
☐ Testicular Lump
☐ Torsion
☐ Hydrocele/Varicocele

SURGERIES:
☐ Tonsils/Adenoids
☐ Appendectomy
☐ Hernia Repair
☐ Other _____

ANY ADDITIONAL PERTINENT INFORMATION: _____

HEALTH HABITS: Tobacco ☐ Yes ☐ No Vape ☐ Yes ☐ No Alcohol ☐ Yes ☐ No Amount/week _____

ALLERGIES: ☐ None ☐ Anaphylaxis ☐ Environmental/Seasonal ☐ Medication _____

MEDICATIONS: (Rx, OTC, vitamins, supplements): _____

Family History Condition	Relationship to Student
Alcoholism	_____
Asthma	_____
Diabetes	_____
Cancer	_____
Sickle Cell Trait/Disease	_____
Elevated Blood Pressure	_____
Heart Disease Before Age 50	_____
Mental Illness	_____
Kidney Disease	_____
Seizure Disorder	_____
Other Significant Health Condition	_____

NIAGARA UNIVERSITY
Office of Health Services

PHYSICAL EXAMINATION

TO BE COMPLETED, SIGNED AND DATED BY HEALTHCARE PROVIDER

NAME	DATE OF BIRTH (MM/DD/YYYY)	GENDER	BLOOD PRESSURE
HEIGHT	WEIGHT	PULSE	SPO2%

TUBERCULOSIS (TB) SCREEN - Required for all students. CIRCLE CORRECT ANSWER
1. Does the student have signs or symptoms of active TB disease? YES / NO
2. Is the student a member of a high-risk group, or from a high-risk country? YES / NO

If answer "No" to both questions, skip TB testing.
If answer "YES" to either question, one of the following tests must be completed:

TUBERCULIN SKIN TEST (Mantoux only)	IGRA (Specify method)	**Xray required if either test is POSITIVE**
Date placed: _____ Date read: _____ Result: ____ mm	QFT-G QFT-GIT T-SPOT Date Tested: _____	Please provide documentation of negative results before the start of the semester.
Interpretation: Negative / Positive	Result: Negative / Indeterminate / Positive	

Chest X-Ray Date: _____ Result: Normal / Abnormal (explain): _____

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

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		

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 (if applicable)? Please circle:

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

Additional Comments/Recommendations: _____

Healthcare Provider Signature_____ **Printed Name**_____ **Date**_____

Address _____ Phone_____

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IMMUNIZATION FORM

If form completed at MD office, it must be SIGNED AND DATED by the medical provider

New York State Public Health Law §2165 requires students enrolled for 6 or more credit hours and born on or after January 1, 1957, to demonstrate immunity to measles, mumps, and rubella. **Acceptable proof includes two doses of MMR vaccine administered after the first birthday** and at least 28 days apart, positive serologic titers, or other documentation approved by the New York State Department of Health. **New York State Public Health Law §2167** requires students enrolled for 6 or more credit hours to receive information regarding meningococcal disease and vaccination. Students must provide documentation of at least one dose of MenACWY vaccine (or completion of a MenB vaccine series) **within the past five years** or signed declination.

IMMUNIZATION RECORD (To be completed by Medical Provider)

Please provide the immunization and/or titer information below. Attach additional documentation if needed.

VACCINE / TEST	REQUIREMENT	DATE ADMINISTERED (MM/DD/YYYY) (for vaccine)	TITER DATE (MM/DD/YYYY) (for titers)
MMR (Measles, Mumps, Rubella)	Dose 1 REQUIRED	Date Dose 1 Administered: _____	Not applicable when MMR vaccine is provided.
	Dose 2 REQUIRED *(Minimum 28 days after Dose 1)*	Date Dose 2 Administered: _____	Not applicable when MMR vaccine is provided.
MEASLES (Titer) *(Lab results must be submitted)*	**2 dose vaccine REQUIRED OR** Positive titer	Dose 1 Date: _____ Dose 2 Date: _____	Titer Date (if applicable): _____
MUMPS (Titer) *(Lab results must be submitted)*	1 dose vaccine REQUIRED OR Positive titer	Vaccine Date (if applicable): _____	Titer Date (if applicable): _____
RUBELLA (Titer) *(Lab results must be submitted)*	1 dose vaccine REQUIRED OR Positive titer	Vaccine Date (if applicable): _____	Titer Date (if applicable): _____
MENINGOCOCCAL (MenACWY)	1 dose vaccine REQUIRED *(within 5 years of enrollment)*	Date Administered: _____	Not applicable.

NOTE: For titers (measles, mumps, rubella), lab results must be submitted with this form.

MEDICAL PROVIDER INFORMATION:

Provider Printed Name: _____ Title: _____

Signature: _____ Date: _____

Office Name: _____ Phone: _____

***If attending the College of Nursing, you will have ADDITIONAL immunization requirements as set forth by the Clinical Sites that include the items below. Please check with the Clinical Coordinator for any changes.**

- 2 doses Varicella or titer showing immunity
- 3 doses Hepatitis B or titer showing immunity
- Tdap within 10 years
- Tuberculosis testing (2 step PPD initially) Single PPD or QuantiFERON yearly
- Influenza yearly or signed waiver
- Covid or signed waiver
- CPR certification
- Physical Exam

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MENINGOCOCCAL VACCINATION DECLINATION FORM

Student Name: _____ **DOB:** _____ **Student ID:** _____

Important Information About Meningococcal Disease

Meningococcal disease is caused by bacteria called *Neisseria meningitidis*. When the linings of the brain and spinal cord become infected, it is called meningococcal meningitis. The disease strikes quickly and can have serious complications, including death.

How Meningococcal Disease Spreads

Meningococcal bacteria are spread through respiratory and throat secretions (saliva or spit) during close or prolonged contact with an infected person or someone who carries the bacteria. Examples include:

- Kissing
- Sharing drinks, eating utensils, or other personal items
- Living in the same household, residence hall, or other close living environment
- Although up to one (1) in ten (10) people may carry the bacteria without becoming ill, meningococcal disease can develop suddenly and become life-threatening.

Individuals at Increased Risk

Risk is increased among:

- Teenagers and young adults
- Students living in college residence halls
- Military recruits
- Travelers to certain countries
- Individuals with certain medical conditions affecting the spleen or immune system
- Smokers
- Persons exposed during an outbreak

Symptoms

Typically appear 3–4 days after infection but may take up to 10 days to develop. Symptoms may include:

- Fever
- Headache
- Stiff neck
- Nausea and vomiting
- Sensitivity to light (photophobia)
- Confusion or altered mental status

Meningococcal Vaccination

- The Centers for Disease Control and Prevention (CDC) recommends meningococcal vaccination for all preteens and teens, as well as certain adults and children at increased risk. Vaccines available in the United States include: MenACWY (Meningococcal Conjugate Vaccine), MenB (Serogroup B Meningococcal Vaccine), MenABCWY (Pentavalent Meningococcal Vaccine)

DECLINATION STATEMENT

I have received and reviewed information regarding meningococcal disease and meningococcal vaccination. I understand the risks associated with meningococcal disease, the benefits of vaccination, and the potential consequences of declining vaccination.

At this time, I choose to decline meningococcal meningitis vaccination.

Student Signature: _____ Date: _____

Parent/Guardian Signature (**Required if student is under 18 years of age**):_____ Date: _____

Resources: Centers for Disease Control and Prevention (CDC) and New York State Department of Health (NYS DOH)

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TUBERCULOSIS (TB) RISK QUESTIONAIRE

Student name_____ **DOB** _____ **Student ID**_____

The health, safety, and well-being of our students are of utmost importance. Because our university enrolls students from diverse geographic regions, all students are required to complete the TB risk assessment as an important part of maintaining a healthy campus community. The TB screening form helps identify students who may have increased risk due to travel, prior residence, occupational exposures, healthcare work, volunteer activities, or other social and environmental factors, allowing appropriate follow-up when needed.

Please answer the following 6 questions:

Have you ever had close contact with persons known or suspected of having tuberculosis?	**Yes**	**No**
Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and/or homeless shelters)?	**Yes**	**No**
Have you been a volunteer or health-care worker who served clients that are at increased risk for active TB (tuberculosis) 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 alcohol and/or drugs?	**Yes**	**No**
Have you had frequent or prolonged visits to one or more of the countries listed below?	**Yes**	**No**
Were you born in one of the countries listed below that have a high incidence of active Tuberculosis disease?	**Yes**	**No**

Angola	Ethiopia	Pakistan
Bangladesh	India	Papua New Guinea
Brazil	Indonesia	Philippines
Cambodia	Kenya	Russian Federation
Central African Republic	Lesotho	Sierra Leone
China	Liberia	South Africa
Congo	Mozambique	Thailand
Democratic People's Republic of Korea	Myanmar	United Republic of Tanzania
	Namibia	Viet Nam
Democratic Republic of Congo	Nigeria	Zimbabwe

Source: World Health Organization. This table includes the global lists of high burden countries for TB used by WHO during the period 2016–2020 (threshold, >10,000 estimated incident TB cases per year).

If you answer "YES" to any of the above questions, Niagara University requires that you submit proof of a NEGATIVE TB or QuantiFERON test prior to the start of the semester. If your TB or QuantiFERON test is POSITIVE, you must submit a negative chest Xray.

Student signature_____ **Date**_____

Parent or guardian signature (if under 18)_____ **Date**_____

P.O. Box 1923 Niagara University, NY 14109 Phone: 716-286-8390 Fax: 716-286-8391 www.niagara.edu/healthcenter

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MEDICATION POLICY

To make treatment more convenient, Niagara University Health Services keeps a limited supply of commonly used medications on-site, including:

- Antibiotics
- Pain relievers and fever reducers
- Cold and flu medications
- Breathing treatments
- Medications for skin irritations and rashes

Medications are provided based on the most common student health needs. Prices reflect our actual cost with no markup and typically range from **$5–$20**, with most medications costing **about $5**.

Please note: Health Services DOES NOT prescribe or dispense controlled substances or narcotics.

YOUR OPTIONS:

Accept On-Site Medication

If medication is available and appropriate for your treatment:

- You may receive it during your visit
- No payment is due at the time of service
- Charges will be billed directly to your student account

Use Your Own Pharmacy

You may choose to fill your prescription through your personal pharmacy and insurance plan. If you do, we are happy to call it in for you and you will be responsible for:

- Obtaining the medication from a pharmacy of your choice
- Arranging your own transportation

IMPORTANT: Please notify Health Services staff before any medication is dispensed if you do not wish to receive medication from our on-site supply.

☐ Accept On-Site Medication

☐ Decline On-Site Medication

Questions? Contact Health Services at **716-286-8390**.

Student Name_____ Student ID_____
Date_____

Signature: _____

NIAGARA UNIVERSITY
Office of Health Services

EXCUSE NOTES FOR MISSED CLASS OR WORK

Niagara University Student Health Services supports student wellness while encouraging personal responsibility and effective communication regarding class and work attendance. The following guidelines outline the Health Services policy regarding excuse notes for missed classes or work due to illness.

1. Students are responsible for attending classes and work assignments, as well as fulfilling all academic and employment obligations.
2. Student Health Services does not provide excuse notes for routine illnesses or minor conditions, such as the common cold or similar short-term illnesses. Exceptions may be made for illnesses that require exclusion from class, work, or campus activities in accordance with state or public health guidelines, including but not limited to influenza, COVID-19, Strep, or other communicable illnesses. In these situations, Student Health Services may provide documentation verifying evaluation and recommended restrictions.
3. Students are encouraged to schedule visits to Student Health Services during times when they do not have classes or work obligations whenever possible.
4. Students who are too ill to attend class or work are encouraged to communicate directly with their faculty member or supervisor. Class attendance and make-up work are matters handled between the student and the instructor.
5. Student Health Services will not issue excuse notes for illnesses or conditions that:
    - Occurred in the past, or
    - Were not evaluated or treated by Student Health Services at the time of illness.
6. Faculty members and supervisors are encouraged to consider this policy when establishing attendance expectations and related requirements.

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