

**Student Health**

Form 1 (A)

Return To:  
Student Health Services**Personal Medical Report****Office Use Only**

Re: \_\_\_\_\_

By: \_\_\_\_\_

Ac: \_\_\_\_\_

**STUDENTS MUST COMPLETE AND SIGN THIS FORM PRIOR TO GOING TO THE PHYSICIAN FOR EXAMINATION.**

As part of your application, we are asking that you complete this questionnaire and answer every question as truthfully as possible. Some questions require a "yes" or "no" answer. "Yes" answers may require an explanation. **Do not leave any question blank.** The College requires a physician's examination in addition to this form for all students taking more than five (5) credits.

**These records are kept in professional confidence in the Student Health Office and are used, if necessary, solely as an aid to providing necessary health care while you are a student at the College.**

New students must report to Student Health Services upon entrance to Davis College.

**GENERAL INFORMATION**
**Campus Location:**  Binghamton  Other \_\_\_\_\_

 Social Security Number \_\_\_\_\_ **U.S. Citizen:**  Yes  No **Gender:**  Male  Female

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Address \_\_\_\_\_ Email \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Anticipated Date of Enrollment: Fall 20 \_\_\_\_ Spring 20 \_\_\_\_ If married, Name of Spouse \_\_\_\_\_

Names and Ages of Children \_\_\_\_\_

**Do you have a documented Learning Disability?**  Yes  No If yes, please submit documentation (IEP, 504 plan, etc.) to the Director of Student Academic Services. Students with documented learning disabilities reserve the right to request special accommodations and/or testing modifications. Arrangements **MUST** be made through the Office of Student Advising.

**EMERGENCY NOTIFICATION (List primary and secondary person to be notified in an emergency)**

Name of Primary Contact Person \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Day Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_ Other \_\_\_\_\_

Name of Secondary Contact Person \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Day Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_ Other \_\_\_\_\_

 Health Insurance that will be used while in college  Private  School

**All Students must complete Student Health Insurance Enrollment/Waiver form. If HMO, specify approved providers in Binghamton area.** \_\_\_\_\_

List ALL allergies: \_\_\_\_\_

List ALL medications currently taking: \_\_\_\_\_

**RESTRICTIVE HEALTH DISABILITY (If answer is YES please explain. Use additional paper if necessary.)**

	YES	NO
Have you ever been refused insurance due to health problems?	<input type="checkbox"/>	<input type="checkbox"/>
Do you now have or have you ever had a permanent restriction in physical activity?	<input type="checkbox"/>	<input type="checkbox"/>
Do you now have or have you ever had a loss of function of a part of the body?	<input type="checkbox"/>	<input type="checkbox"/>
Do you now have or have you ever had a permanent medical disability such as diabetes, blindness, etc.?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been admitted to the hospital?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any operations?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any fractures or broken bones?	<input type="checkbox"/>	<input type="checkbox"/>

Explain all YES answers: \_\_\_\_\_

**Student Health****Form 1 (B)**Return To:  
Student Health Services**Personal Medical Report****Office Use Only**

Re: \_\_\_\_\_

By: \_\_\_\_\_

Ac: \_\_\_\_\_

**STUDENTS MUST COMPLETE AND SIGN THIS FORM PRIOR TO GOING TO THE PHYSICIAN FOR EXAMINATION**

Name \_\_\_\_\_ Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

**FAMILY HISTORY** (Blood relatives include: parents, grandparents, brothers, sisters, etc.)

	YES	NO		YES	NO		YES	NO
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
Anemia (Sickle Cell)	<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Trait	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Suicide	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>

**HEALTH RECORD** Have you had any of the problems listed below?

	YES	NO		YES	NO
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Do you use alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Have you abused alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been diagnosed with cancer?	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Type _____ Treatment _____		
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever received treatment or counseling for a nervous condition, personality/character disorder, emotional problem or depression?	<input type="checkbox"/>	<input type="checkbox"/>
Constant Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Treatment type _____		
Cystitis, Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	Counselor's name/facility _____		
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Are you currently using any illegal drugs?	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever abused or been dependent on drugs (prescription or illegal)?	<input type="checkbox"/>	<input type="checkbox"/>
Eye Problem	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Fibrocystic Breasts	<input type="checkbox"/>	<input type="checkbox"/>	Type _____ Treatment _____		
Gall Bladder	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been diagnosed with epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Medication taken (specify) _____		
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been diagnosed with a heart problem? (Heart attack, heart murmur, enlarged heart, rheumatic heart, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Do you have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	Type _____ Medication _____		
Kidney Problem	<input type="checkbox"/>	<input type="checkbox"/>	Do you have high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Knee Injury	<input type="checkbox"/>	<input type="checkbox"/>	Medication _____		
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been diagnosed with a mental illness?	<input type="checkbox"/>	<input type="checkbox"/>
Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Specify _____ Treatment _____		
Obesity (20 lbs. over)	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever attempted suicide?	<input type="checkbox"/>	<input type="checkbox"/>
Peptic Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a Sexually Transmitted Disease?	<input type="checkbox"/>	<input type="checkbox"/>
Persistent Rash or Pimples	<input type="checkbox"/>	<input type="checkbox"/>	Type _____ Treatment _____		
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Current medication _____		
Skin Lesion That Will Not Heal	<input type="checkbox"/>	<input type="checkbox"/>	Have you consulted or been treated by clinics, physicians healers or other practitioners NOT mentioned above in the last five (5) years?	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Specify _____		
Stomach or Intestinal Trouble	<input type="checkbox"/>	<input type="checkbox"/>			
Tension Headaches	<input type="checkbox"/>	<input type="checkbox"/>			
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>			
Unexplained Fever/Chills	<input type="checkbox"/>	<input type="checkbox"/>			
Unexplained Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>			
Do you currently smoke?	<input type="checkbox"/>	<input type="checkbox"/>			
Do you use smokeless tobacco?	<input type="checkbox"/>	<input type="checkbox"/>			

If you regularly use assistive devices such as hearing aids, glasses, contact lenses, braces (other than dental) please specify.

Are you currently under the care of a physician, psychiatrist, psychologist or counselor?  Yes  No If yes, specify reason and give name, address and phone number of professional \_\_\_\_\_

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

*If applicant is under 18 years of age, parent/guardian must sign.*

Personal disclosure on this form will not result in disciplinary measures; however, falsification of information on any Davis College document may alter student status or prevent further registration. Davis College does not discriminate on the basis of race, color, sex, disability or ethnic origin.

400 Riverside Dr. ♦ Johnson City, NY ♦ 13790 ♦ Phone - 607.729.1581 ext. 337 ♦ Fax - 607.770.6886 ♦ health@davisny.edu 5/04:7/06

**Student Health**

Form 2 (A)

Return To:  
Student Health Services**Physician's Evaluation Form****Office Use Only**

Re: \_\_\_\_\_

By: \_\_\_\_\_

Ac: \_\_\_\_\_

**To the Examining Physician:** Please review the student's history, complete this form and comment on all POSITIVE answers. The information supplied does not affect the student's status; it is used, if necessary, as a background for providing health care. This information is strictly for the use of Student Health Services and is not released without student consent. Please make sure all information is complete and all laboratory tests performed. Incomplete forms may result in delay of student's registration.

**PART I – PLEASE PRINT**

Social Security or Student ID Number \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Birth Date \_\_\_\_\_ Gender  M  F

Home Address \_\_\_\_\_ Email \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

**PART II – TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER.** All information must be in English.**A. M.M.R. (Measles, Mumps, Rubella)** (Two doses required by New York State law for students born after January 1, 1957.)

1. Dose 1 given at age 12-15 months or later Mo \_\_\_\_ Yr \_\_\_\_
2. Dose 2 given at age 4-6 years or later, and at least one month after first dose Mo \_\_\_\_ Yr \_\_\_\_

**B. Tetanus-Diphtheria** (Primary series with DTaP or DTP and booster with Td in the last ten years meets requirement. Refer to ACIP for details.)

1. Primary series of four doses with DTaP or DTP #1 Mo \_\_\_\_ Yr \_\_\_\_ #2 Mo \_\_\_\_ Yr \_\_\_\_  
#3 Mo \_\_\_\_ Yr \_\_\_\_ #4 Mo \_\_\_\_ Yr \_\_\_\_
2. Tetanus-Diphtheria (Td) booster with the last ten years Mo \_\_\_\_ Yr \_\_\_\_

**C. Polio** (Primary series in childhood meets requirement; three primary series schedules are acceptable. Refer to ACIP for details.)

1. OPV alone (oral Sabin 3 doses) #1 Mo \_\_\_\_ Yr \_\_\_\_ #2 Mo \_\_\_\_ Yr \_\_\_\_ #3 Mo \_\_\_\_ Yr \_\_\_\_
2. IPV alone (injected Salk 4 doses) #1 Mo \_\_\_\_ Yr \_\_\_\_ #2 Mo \_\_\_\_ Yr \_\_\_\_ #3 Mo \_\_\_\_ Yr \_\_\_\_ #4 Mo \_\_\_\_ Yr \_\_\_\_
3. IPV/OPV sequential #1 Mo \_\_\_\_ Yr \_\_\_\_ #2 Mo \_\_\_\_ Yr \_\_\_\_ #3 Mo \_\_\_\_ Yr \_\_\_\_ #4 Mo \_\_\_\_ Yr \_\_\_\_

**D. Varicella** (Either a history of chicken pox, a positive Varicella antibody or two doses of vaccine given at least one month apart if immunized after age 13 years meets the requirement.)

1. History of Disease  Yes  No
2. Varicella antibody  Reactive  Non-Reactive Mo \_\_\_\_ Yr \_\_\_\_
3. Immunization Dose #1 Mo \_\_\_\_ Yr \_\_\_\_  
Dose #2 Given at least one month after first dose if age 13 years or older Mo \_\_\_\_ Yr \_\_\_\_

**E. Hepatitis** (Three doses of vaccine or a positive Hepatitis surface antibody meets the requirement.)

1. Immunization #1 Mo \_\_\_\_ Yr \_\_\_\_ #2 Mo \_\_\_\_ Yr \_\_\_\_ #3 Mo \_\_\_\_ Yr \_\_\_\_
2. Hepatitis B surface antibody  Reactive  Non-Reactive Mo \_\_\_\_ Yr \_\_\_\_

**F. Influenza** (Annual immunization recommended to avoid disruption to academic activities)

Highly recommended for individuals with compromised immune systems. Mo \_\_\_\_ Yr \_\_\_\_

**G. Meningococcal (REQUIRED for all freshmen living in campus housing. Any undergraduate less than 25 years who wishes to reduce their risk of disease can consider the vaccine. Students with immunodeficiency such as complement deficiency or asplenia should receive vaccine q 3-5 years.)**

Quadrivalent polysaccharide vaccine (Menomune™) Mo \_\_\_\_ Yr \_\_\_\_ Menactra (Conjugated Vaccine) Mo \_\_\_\_ Yr \_\_\_\_

**H. Tuberculosis Screening** (PPD required regardless of prior BCG inoculation.)

1. PPD (Mantoux) within the past 12 months (tine or monovac not acceptable)  
Result:  Negative  Positive mm induration (horizontal diameter) Mo \_\_\_\_ Yr \_\_\_\_
2. If PPD is positive, chest X-ray required. Result:  Normal  Abnormal Mo \_\_\_\_ Yr \_\_\_\_
- If chest X-ray is abnormal, treatment plan must be attached.**

**An official record must be attached OR your medical provider must sign this form.**

Healthcare Provider Name \_\_\_\_\_

Signature \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

**Student Health****Form 2 (B)**Return To:  
Student Health Services**Physician's Evaluation Form****Office Use Only**

Re: \_\_\_\_\_

By: \_\_\_\_\_

Ac: \_\_\_\_\_

Name \_\_\_\_\_ Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

**PART III – PHYSICAL EXAMINATION**

Date of Physical Exam: (Month/Day/Year) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Blood Pressure: \_\_\_\_\_ Gender: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Vision Corrected: \_\_\_\_\_ Uncorrected: \_\_\_\_\_ Right: 20/ \_\_\_\_\_ Left: 20 / \_\_\_\_\_

**LABORATORY TESTING**

Hemoglobin and/or Hematocrit (numerical values): \_\_\_\_\_ Urine Dipstick: \_\_\_\_\_

Sugar: \_\_\_\_\_ Albumin: \_\_\_\_\_

**SYSTEM REVIEW**

	Normal	Abnormal	Explanation
Head, Ears, Nose, Throat			
Respiratory			
Cardiovascular			
Gastrointestinal			
Hernia			
Eyes			
Genitourinary			
Musculoskeletal			
Metabolic / Endocrine			
Neuropsychiatric			
Skin			

1. Is there loss or seriously impaired function of any paired organ?  Yes  No
2. Is the patient now under treatment for any medical or emotional condition?  Yes  No
3. Are there any restrictions on physical activity related to physical education classes, intercollegiate or intramural sports?  Yes  No
4. Do you have any other comments and / or recommendations?  Yes  No
5. Please comment on any "yes" answers. \_\_\_\_\_

I have examined the above named student AND reviewed their Personal Medical Report. It is my professional opinion that the student is physically and psychologically able, except as noted above, to undertake college studies.

Examiner's signature: \_\_\_\_\_ (If exam is performed by NP/PA, see \*\* below).

**[Immunization record (Part II) must also be signed by a healthcare provider.]**

PRINT name and title: \_\_\_\_\_ Registration # and state: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Date \_\_\_\_\_

\*\* Name and active state license registration of collaborating MD must be identified below:

PRINT collaborating MD's name: \_\_\_\_\_ Registration # and state: \_\_\_\_\_

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400 Riverside Dr. • Johnson City, NY • 13790 • Phone - 607.729.1581 ext. 337 • Fax - 607.770.6886 • health@davisny.edu 5/04: 7/06

# Meningococcal Meningitis

Don't Wait.  
Vaccinate.

**T**here is a rare but sometimes deadly disease, called meningococcal meningitis, that strikes adolescents and young adults.

The disease spreads quickly and within hours of the first symptoms can cause organ failure, brain damage, amputations of limbs, or death.

Parents and their adolescent and college-bound children should learn more about meningococcal meningitis and prevention.

Vaccination can prevent most cases of the disease.

## Talk to Your Doctor About Meningitis Vaccination

Parents and their children are encouraged to learn more about meningococcal meningitis and to talk to a physician about immunization and other prevention approaches.

## National Meningitis Association

The National Meningitis Association (NMA) is a nonprofit organization established in July 2002.

Its mission is to educate families, medical professionals, and others about bacterial meningitis and prevention approaches to the disease.

For more information about NMA and its activities, or to contact a member of NMA, please call 1-866-FONE-NMA (1-866-366-3662) or visit [www.nmaus.org](http://www.nmaus.org).



**Meningitis:  
Possible to Prevent.  
Dangerous to Ignore.**



National Meningitis Association  
22910 Chestnut Road  
Lexington Park, MD 20653  
1-866-FONE-NMA  
[www.nmaus.org](http://www.nmaus.org)



### Facts About Meningococcal Meningitis

- o Adolescents and young adults have an increased incidence of meningococcal disease, accounting for nearly 30 percent of all U.S. cases. One out of four cases among adolescents will result in death.
- o Up to 83 percent of meningococcal disease cases among adolescents and young adults are potentially vaccine-preventable.
- o College students living in dormitories are at an increased risk of getting this contagious disease compared to the general college population.
- o Each year, meningococcal disease strikes nearly 3,000 Americans, and 10 to 12 percent of those infected will die.
- o Up to 20 percent of survivors have long-term disabilities, such as brain damage, hearing loss, or limb amputations.
- o The disease can take one of two forms: swelling of membranes that surround the brain and spinal cord (meningococcal meningitis), or the more deadly meningococemia, an infection of the blood.
- o Meningococcal disease is caused by bacteria called *Neisseria meningitidis*.

### Adolescents, Young Adults at Special Risk

Lifestyle factors common among adolescents and young adults seem to be linked to the disease. These include crowded living situations such as dormitories, boarding schools and sleep-away camps, going to bars, smoking, and irregular sleep habits.



### Consider Vaccination

Immunization can prevent up to 83 percent of meningococcal disease cases in adolescents and young adults:

- o The Food and Drug Administration has approved a meningococcal conjugate vaccine for use among 11- to 55-year-olds, which is expected to provide longer duration of immunity and decrease carriage of meningococcal bacteria among adolescents, preventing the spread of the disease.
- o Vaccination protects against four of the five types of the bacteria responsible for meningococcal disease in the U.S., and for the majority of cases in adolescents and young adults.
- o As with all vaccines, there may be minor reactions (pain and redness at the injection site or a mild fever).



### Be Alert: Early Flu-Like Symptoms

Meningococcal disease often is misdiagnosed because its early signs are much like those of the flu or migraines. Symptoms may include high fever, headache, stiff neck, confusion, nausea, vomiting, and exhaustion.

Later, after the disease has taken hold, a rash may appear. If any of these symptoms are present and are unusually sudden and severe, call a physician. Don't wait.

### How Meningitis Is Spread

The disease is spread through air droplets and direct contact with someone who is infected. That includes coughing, kissing, and sharing cigarettes, utensils, cups, or lip balm – anything an infected person touches with his or her mouth.

Adolescents and young adults can reduce their risk by being vaccinated. They can also take special precautions by not sharing certain things: utensils, beverages, cigarettes, etc.

Most cases occur in late winter to early spring.

### Immunization Information

The Centers for Disease Control and Prevention and other key medical groups\* recommend routine meningococcal disease immunization (one shot) for:

- o Young adolescents at the preadolescent doctor's visit (11-12 years)
- o If not previously vaccinated, immunization is recommended for high school entry or at age 15 (whichever comes first)
- o College freshmen living in dormitories
- o Vaccination should be made available to those who ask to be immunized.

\*American Academy of Family Physicians, American Academy of Pediatrics, American College Health Association, American Medical Association, Society for Adolescent Medicine



### Find Out More

For more information about meningococcal disease and immunization that can help prevent it, visit the following Web sites:

- o National Meningitis Association  
[www.nma-us.org](http://www.nma-us.org)
- o American Academy of Family Physicians  
[www.aafp.org](http://www.aafp.org)
- o American Academy of Pediatrics  
[www.aap.org](http://www.aap.org)
- o American College Health Association  
[www.acha.org](http://www.acha.org)
- o Centers for Disease Control and Prevention  
[www.cdc.gov](http://www.cdc.gov)

For medical advice about meningococcal immunization, consult your physician, college health service, or local public health department.

**Student Health****Form 3**

Return To:  
Student Health  
Services

**Meningitis Information Response Form****Office Use Only**

Re: \_\_\_\_\_  
Sent: \_\_\_\_\_  
Rec. By: \_\_\_\_\_  
\_\_\_\_\_

New York State Public Health Law **requires** that all college and university students enrolled for at least six (6) semester hours or the equivalent per semester, or at least four (4) semester hours per quarter, complete and return this form to:

Student Health Services  
Davis College  
400 Riverside Drive  
Johnson City, NY 13790

As of January 1, 2006, Davis College **requires** that **ALL** Freshmen living in the college campus housing be vaccinated against meningococcal meningitis. This is in keeping with the recommendations of the Centers for Disease Control (CDC), the Advisory Committee on Immunization Practices (ACIP) and the American College Health Association (ACHA).

High School students taking six (6) credits or more on campus *must also* show proof of having had this vaccine prior to registration.

Other college students under age 25 may choose to receive the meningococcal vaccine to reduce their risk of disease.

**Please Note: According to Public Health Law, no institutions shall permit any student to attend the institution in excess of 30 days without having this form on file.**

I have had the meningococcal meningitis vaccine within the last 10 years. Date Received: \_\_\_\_\_

**Check one box and sign below:**

I am (for students under age 18: My child is):

- A Freshman student residing in campus housing. **(Vaccine required by Davis College)**
- A High School student taking six (6) credits or more **on campus**. **(Vaccine required by Davis College)**
- A Freshman living off-campus OR a High School student taking five (5) credits or less.
- An upperclassman student (non-Freshman) and 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 **will not** obtain immunization against meningococcal meningitis disease.

\_\_\_\_\_  
Student Signature (Parent/Guardian if student under age 18)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Student's Name

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Student Email

\_\_\_\_\_  
Day Phone

\_\_\_\_\_  
Evening Phone

**Please Note: This vaccine is NOT available through our campus Health Services. Check with your personal physician or local County Health Department for availability of the vaccine and immunization clinics. You need to know that this vaccine is expensive and may not be covered by all insurance carriers.**





Student Health Insurance

Enrollment / Waiver Form # 5

ALL students must return this form to Student Health no later than Registration Day.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Email: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Location:

\_\_\_\_\_ Johnson City \_\_\_\_\_ Albany \_\_\_\_\_ Syracuse

Davis College requires that ALL students taking 6 credits or more (per semester) have health insurance coverage.

\_\_\_\_\_ I wish to enroll in the Davis College Insurance Plan currently \$650 for 12 months of coverage. Claim forms are available online at www.maskin.com or at the Student Health Office.

\_\_\_\_\_ I have private insurance coverage. Attached is a copy of my insurance card. If you fail to return this form with a copy of your insurance card by Registration Day, you will be enrolled in the college plan and be billed the non-refundable charge for insurance.

\_\_\_\_\_ I am currently taking less than 6 credits and recognize it is my responsibility to notify Student Health of my health insurance coverage at the time I increase to 6 credits per semester.

\*\*I acknowledge that I am legally responsible for any and all medical expenses not covered by insurance incurred by myself/son/daughter. I acknowledge that the above information is true. I recognize that falsification of information on any Davis College document may alter my student status or prevent further registration.

\_\_\_\_\_  
Signature (Parent/Guardian if student under 18 years of age) \_\_\_\_\_ Date