For Office Use Only

Utilities----------

Notified----------

Incomplete------

Complete---------

Entered By--------

WAGNER COLLEGE

HEALTH RECORD

Graduate Student

Second Degree

Center for Health and Wellness
One Campus Road
Staten Island, NY 10301
Phone: (718 390-3158
Fax: (718) 420-4170

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LAST NAME(PRINT) FIRST NAME MIDDLE DOB ID#

HOME ADDRESS (NUMBER AND STREET) CITY OR TOWN STATE ZIP CODE

(AREA CODE)HOME TEL. NUMBER (AREA CODE) STUDENT CELL NUMBER

EMERGENCY CONTACT: NAME/RELATIONSHIP (AREA CODE) CELL NUMBER EMAIL ADDRESS

SEMESTER/YEAR ENTERING_____

FAMILY HISTORY					Have any of your relatives had any of the following?			
	State of Health	Occupation	Age at Death	Cause of Death		YES	NO	Relationship
Father					Arthritis			
Mother					Cardiovascular Disease			
Siblings:					Cancer			
					COPD			
					Diabetes			
					Epilepsy			
					Kidney Disease			
					Seizure Disorder			

PERSONAL HISTORY:

HAVE YOU HAD?	YES	NO	HAVE YOU HAD?	YES	NO
ADD/ADHD			Epilepsy/Seizure Disorder		
Allergies/seasonal			Hearing Impaired		
Anemia/Bleeding Disorder			Heart Condition/murmur/MVP		
Anxiety			Hepatitis		
Arthritis			Hypertension		
Asperger's Syndrome			Kidney Disease		
Asthma			Lyme's Disease		
Autoimmune disease			Migraine Headache		
Bipolar Disorder			Mononucleosis		
Cancer			Orthopedic disease/injury/surgery		
Chron's Disease/Colitis/IBS/Peptic Ulcer			Pneumonia		
			Recovery/Alcohol/		
Concussion/Head Injury/Traumatic Brain Injury			Sickle Cell Disease/Trait		
Chronic Disease			Thyroid		
Depression			Tourettte's Syndrome		
Diabetes 1 or 2			Vision Impaired		

PROVIDE COMMENTS ON ALL "YES" ANSWERS IN SPACE BELOW:

_____
_____
_____

PLEASE COMPLETE THE FOLLOWING: Hospitalizations or Operations (give dates & procedures)

_____
_____

Serious Injuries (including fractures, motor vehicle accidents, etc.)

_____
_____

Counseling for Emotional Disorders/Psychiatric Treatment/Drug or Alcohol Rehabilitation_____
_____

_____

Allergies (medications, food, environment, latex , insects, chemicals,animals)

_____
_____

ALL Medications: _____

Tobacco use/amount: _____

Alcohol use/amount: _____

THE INFORMATION I HAVE PROVIDED IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

_____

STUDENT SIGNATURE DATE

_____

PARENT SIGNATURE (if student is under 18 years of age) DATE

I hereby give consent for treatment and immunizations by the Wagner College Health Staff_____

I give permission to discuss my illness with my parents/guardian_____
(To be signed by student and parent/guardian if student is under 18 years of age)

STUDENT IMMUNIZATION RECORD: MUST BE SUBMITTED PRIOR TO CLASS REGISTRATION

Name: _____ID#_____

ALL INFORMATION MUST BE IN ENGLISH

*This requirement is in compliance with NYS Public Health Law, Section 2165 MONTH/DAY/YEAR

A. *MMR (Measles, Mumps, Rubella) if given instead of individual immunizations **(required)**

1. Dose 1 - Immunized at 12 months after birth or later ……._____/____/_____
2. Dose 2 - Immunized at least 30 days after 1st dose…….._____/____/_____

B. *Measles (Rubeola) Check appropriate boxes **(required)**

1. Born before 1957 and therefore considered immune……YES ☐ NO ☐
2. Had the disease. Confirmed by physician record…….._____/_____/_____
3. Attached copy of original lab test titer with values …… Specify date of titer _____/_____/_____

*This requirement is in compliance with NYS Public Health Law Section 2167

C. ***MENINGOCOCCAL TETRAVALENT**(One dose within 10 years) **(required)**
(A,C,Y,W-135/One dose – for college freshmen living in dormitories/residence halls, persons with terminal complement deficiencies or asplenia, laboratory personnel with exposure to aerosolized meningococci, and travelers to hyperendemic or endemic areas of the world. Non-freshmen college students may choose to be vaccinated to reduce their risk of meningococcal disease.)
CHECK ONE (1) BOX ONLY

☐ Meningococcal vaccine Name and date of vaccine: _____

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

Signed_____ Date_____
Student/Parent (if student is under 18)

D. **Medical Exemption**: Attach report from your licensed medical provider if vaccination is medically contraindicated.

E. **Religious Exemption**: Attach **Notarized** documentation from Religious Affiliate _____

☐ Tdap Booster within 10 years

☐ PPD planted Date_____ Result _____Date_____