State University of New York
College of Environmental Science and Forestry

ESF Student Health Form

All incoming new students (first-year, transfer, graduate, and international) who are enrolled for any on-campus course must complete and return this ESF Student Health Form. **This form must be mailed, faxed, emailed, or delivered directly to Crouse Medical Practice (attn: ESF Student Health Center)**:

- 739 Irving Ave., Suite 300, Syracuse, NY, 13210
- FAX: 315-766-1614
- Email: ESFhealthservices@crousemed.com

on or before August 1 (for fall semester matriculation) or January 2 (for spring semester matriculation)**.** If this form is not received by Crouse Medical Practice by the deadline, students will have a hold placed on their record and risk having their classes cancelled.

Part I: Personal Information

STUDENT INFORMATION *PLEASE PRINT*	DATE:
Last Name, First Name, MI	**SUID#**
Permanent Street Address/PO Box/Apt #	**City, State, Zip**
Student Status – Circle one: New First-year Student New Transfer Student New Graduate Student International Student Continuing Student	**Cell Phone**
Date of Birth (MM/DD/YYYY)	**Preferred Gender**

EMERGENCY CONTACT		
Name	**Relationship**	**Home Phone**
Address	**City, State, Zip**	**Business/Cell Phone**

PRIMARY CARE PHYSICIAN	**Phone**
Address, City, State, Zip	**Fax**

MEDICAL CARE AUTHORIZATION

I, the undersigned, do herby authorize a practicing physician or nurse practitioner to exercise for me and on my behalf all my rights and duties with reference to consenting to appropriate medical, surgical, or hospital treatment, including mental health care, deemed necessary for the medical or emergency care of myself/my child. **If under 18 years of age, signatures of both parent/guardian and student are required.**

Student: ____ Date: ____________________

Parent/Guardian: _______________________________________ Date: ____________________

Part II: Immunization Record

All students are directed to review and comply with ESF's Immunization Policy. If, however, you are requesting a religious or medical exemption to the immunization requirements, please proceed to Part VI, below.

Section I: Proof of Measles, Mumps, & Rubella (MMR) Immunity[1]

This section MUST be completed, signed, and stamped by a Health Care Provider or the form will not be processed. *Each student must also provide evidence of immunity for each disease, which must be in the form of laboratory reports attached to this form.*

HEALTH CARE PROVIDER STAMP IS REQUIRED FOR SECTION I:

MMR (Measles, Mumps, & Rubella combined vaccine)

Two Doses Required:

____ Dose 1 received: MO_____/DATE_____/YEAR_____

____ Dose 2 received: MO_____/DATE_____/YEAR_____

OR

MMR given as individual vaccines:

Measles:

____ Dose 1 received: MO_____/DATE_____/YEAR_____

____ Dose 2 received: MO_____/DATE_____/YEAR_____

AND

Mumps:

____ Date live vaccine received: MO_____/DATE_____/YEAR_____

AND

Rubella:

____ Date live vaccine received: MO_____/DATE_____/YEAR_____

***Healthcare Provider Signature**: (MD/NP/PA): ______________________ Date: ___________

Section 2: Meningococcal Information and Certification

Pursuant to NYS Public Health Law § 2167, all students regardless of age, must read and certify that they have been informed about meningitis at https://www.health.ny.gov/publications/2168/.
Students are also encouraged to read about meningitis at http://www.immunize.org/catg.d/p4210.pdf and http://media.chop.edu/data/files/pdfs/vaccine-education-center-meningococcus.pdf. All students must demonstrate compliance with this requirement before the thirtieth (30th) day of classes after enrollment. This requirement applies to all students, including out-of-state residents and international students. Failure to comply with this requirement will result in the Registrar being notified and the student being administratively withdrawn from classes. The student may also be required to vacate campus.

Certification and Signature

Please check one of the following and sign below.

____ I have (or for students under 18, my child has) received the meningococcal meningitis vaccine within the preceding 10 years.

Date received: MO_____/DATE_____/YEAR_____

OR

____ I have (or for students under 18, my child has) read, or had had explained to me, the information provided above regarding meningococcal meningitis disease. I am aware that immunization against this disease is strongly recommended and I (or my child) will obtain the meningococcal meningitis vaccine within 30 days.

OR

____ I have (or for students under 18, my child has) read, or had had explained to me, the information provided above regarding meningococcal meningitis disease. I am aware that immunization against this disease is strongly recommended and is available from any health care provider and/or county Department of Health. I, however, decline the vaccine.

Signature Section is Required:

Date: ____

Student Signature: ____

Parent/Guardian Signature (if student is under 18): _______________________________

Part III: Recommended Immunizations

Although not required, ESF recommends that all students receive immunizations for the following diseases: Hepatitis A & B, Influenza, Tdap, Tetanus-Diptheria, Meningitis, HPV, Polio, and Varicella. If you have received any of these recommended immunizations and wish to report them, please indicate in the space below, together with your Health Care Provider's signature and stamp.

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HEALTH CARE PROVIDER STAMP IS REQUIRED FOR SECTION I:

Healthcare Provider Signature: (MD/NP/PA): ________________________ Date: ___________

PART IV: Information for Students with Disabilities

Students who have a disability or require accommodations are encouraged to contact the **Syracuse University Office of Disability Services** (disabilityservices.syr.edu or (315) 443-4498) to register at the beginning of every semester. The Syracuse University Office of Disability Services coordinates these services for ESF students and determines eligibility for accommodations. Students will be asked to submit the necessary paperwork directly to Syracuse University to determine what accommodations they qualify for. If you are not sure whether you are eligible to receive accommodations and/or are not sure how to navigate this process, you are welcome to speak with an ESF Student Affairs staff member at any time.

PART V: Requirement for International Students to Undergo Tuberculosis Screening

All international students must undergo a Tuberculosis (TB) screening prior to arrival to campus. Crouse Medical Practice will provide this screening if necessary. There may be a fee associated with receiving these services that is payable to Crouse Medical Practice at the time the service is provided. To schedule an appointment for a tuberculosis screening, contact the ESF Student Health Center at Crouse Medical Practice at (315) 315-766-1628.

Failure to adhere to this requirement will result in the Registrar being notified and the international student being administratively withdrawn from classes. The student may also be required to vacate campus.

Turn page over for the Part VI: Immunization Exemption Request

Part VI: Immunization Exemption Request

Any student who believes they should be exempt from the immunization requirements must fill out this section and submit it directly to Crouse Medical Practice before the thirtieth (30th) day of classes after your enrollment. Failure to do so will result in the Registrar being notified and the student being administratively withdrawn from classes. The student may also be required to vacate campus.

Section 1: Religious Exemptions

Please state your sincerely held religious beliefs that are contrary to the required immunizations. You should explain the length of time that you have adhered to such religious principles, together with the impact that the immunization(s) would have on your religious beliefs. Please provide documentation to support your request.

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Section 2: Medical Exemptions

Please state the medical basis for your medical exemption request. This information must include the specific vaccine(s) that you believe you should be exempt from, together with a valid medical reason. You should also indicate the proposed dates of your exemption. You must also provide signed and stamped medical documentation from your Health Care Provider as medical evidence to support your request.

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PLEASE REMEMBER TO MAKE A COPY OF THIS FORM FOR YOUR RECORDS.

Last Updated: May__, 2017