



MEDICAL CONSENT FORM # 4
FOR STUDENTS UNDER EIGHTEEN ONLY

TO: Parents and Guardians of students under 18 years of age

Students attending college are generally considered independent adults and parental consents for medical care for those under 18 years of age are not routinely required. However, there are occasional situations in which a parental signature is desirable for treatment. Vaccinations and minor surgical procedures are two examples of such situations.

To avoid delay in such treatment interventions, you are encouraged to sign the authorization below for medical or emergency treatment. Please return the form to the college C/O of Student Health Services. Should the student seek or be referred for care at an off-campus facility, the policies and procedures of that facility will be followed.

Parents and guardians are reminded that the college Health Services Department only provides First Aid, care for general sickness, advice on health issues & ordinary over the counter medicines. When deemed advisable, referrals are made to local clinics and physicians. Davis College students have two excellent hospitals within two miles of the campus for emergencies.

It is the policy of the college Student Health Services that ALL student medical records are confidential. No information is released without written authorization of the student except in certain emergencies, public health situations or under a court-ordered subpoena.

CONSENT OF PARENT OR GUARDIAN FOR MEDICAL OR EMERGENCY TREATMENT

I, _____, pursuant to the authority vested in me
(Name of parent or guardian)

as: parent / guardian of _____ DOB: _____ do hereby authorize
(circle one) (Name of student)

Student Health Services of Davis College to give treatment or refer my _____
(son or daughter)

for appropriate medical treatment. This does not include the right to perform surgical procedures without my further consent, except in the case of emergency & when after all effort has been made to locate me, I am found unavailable.

Student's date of birth _____ Social Security number _____

Numbers where I can be reached: () _____ () _____

Evening phone: () _____ Other: () _____

Secondary contact: _____ Relationship: _____

Day time phone: () _____ Evening phone: _____

Signature: _____ Date: _____

Return to: Student Health, 400 Riverside Dr. Johnson City, NY 13790* phone: 607.729.1581 ext. 337
*Fax: 607.584.7656, health@davisny.edu

Student Health Insurance Enrollment / Waiver Form

ALL students must return this form to Student Health **no later than Registration Day. NO EXCEPTIONS!**

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Email: _____

Home Address: _____

City/State: _____ Zip: _____ Phone: _____

Where are you taking classes?

_____ Johnson City _____ Albany _____ Syracuse _____ Elsewhere (specify)

EVERYONE enrolled for 6 credits or more **will automatically be billed** a non-refundable charge for college health insurance **UNLESS** a copy of a valid insurance card is attached showing current medical insurance coverage.

Waiver:

_____ Attached is a copy of my insurance card, as described above, which **exempts** me from the College health insurance plan.

_____ I am currently taking less than 6 credits. At such time that I increase my number of credits to 6 or more, I recognize it is my responsibility to provide Student Health with a copy of my valid, current insurance card or enroll in the College program through Student Health.

**** 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 is under 18 years of age)

Date

Enrollment Acknowledgement:

_____ Because I have not provided proof of current medical coverage, I am enrolling in the Davis College Insurance Plan currently for \$732 for 12 months of coverage (Aug.'10-Aug.'11) or \$465 for Jan.'11-Aug.'11. Rates for a plan including dependents are available upon request. The insurance brochure is available from the Student Health Office or at www.davisny.edu/studentlife/healthservices.htm

Claim forms are available online at www.maksin.com or at the Student Health Office

Student Notice – By placement of your signature here on, acknowledgement is made that: 1) you have carefully read, understand, and agree to the terms and conditions of this coverage as detailed in the brochure; 2) you and any covered family member(s) meet the eligibility requirements as described within the insurance brochure; 3) if at any time it is determined you, or any family member, did not meet the eligibility requirements for this coverage, the only liability the Company has is the refund of premium, subject to any claims for which benefits have been paid prior to the discovery of the ineligibility; 4) the Company assumes no responsibility for notification to the covered person prior to or at the termination of coverage for any insured period.

Signature (Parent/Guardian if student is under 18 years of age)

Date

Please return to: Joanna Johnson, Director of Student Health, Davis College 400 Riverside Dr., Johnson City, NY 13790
health@davisny.edu ♦ 607.729.1581 ext. 337 (Phone) ♦ 607.584.7656 (Fax)

Updated: 7/10

DAVIS COLLEGE - 2010-2011 STUDENT ACCIDENT & SICKNESS PROGRAM

Administrator Policy # **CHH0043201** / Underwriter Reference # **CAS9499414**

The following is a brief description of an Accident and Sickness Insurance Program designed for students attending Davis College ("the Policyholder"). The Master Policy issued to the College contains the complete details of coverage and is the governing document. It may be inspected during normal business hours at the Student Health Service. The Student Sickness & Accident Policy is underwritten by National Union Fire Insurance Company of Pittsburgh, Pa. ("the Company") with its principal place of business in New York, New York.

ELIGIBILITY: All students formally enrolled in a full-time course of study leading to a degree are eligible to enroll in this insurance plan. Matriculated students, enrolled from between 6 and 11 credits, are also eligible to purchase the Policy.

A Covered Student may enroll dependents (the Covered Student's spouse and the Covered Student's unmarried children up to age 19 who are not self-supporting). To obtain a dependent enrollment form, visit the Student Health Service. All premiums must be paid by check or money order.

TERM OF COVERAGE: Coverage begins 12:01 AM on August 28, 2010 and terminates 11:59 PM on August 27, 2011. Except for medical withdrawal due to a covered injury or sickness, any student withdrawing from the College during the first thirty-one (31) days of the period for which coverage is purchased shall not be covered under the Policy and a full refund of premium will be made. Students withdrawing after such 31 days will remain covered under the Policy for the full period for which premium has been paid, and no refund will be allowed. Covered Persons entering the armed forces of any country will not be covered under the Policy as of the date of such entry. A pro-rata refund of premium will be made to such persons upon written request received by the Company.

OPEN ENROLLMENT: Premium for each enrollment period must be received within 31 days from the effective date of the enrollment period. However, a student who does not enroll during an Open Enrollment Period may not apply for coverage until the next Open Enrollment Period unless an application is made within 31 days of the following qualifying events: 1) Birth/adoption; 2) Marriage; and 3) Loss of benefits due to spouse's/parent's loss of employment. An eligible student may enroll for coverage for his or her Dependents only within the 31 days immediately following the beginning of each Policyholder's term of coverage; or within 31 days of marriage, birth, or adoption.

BASIC ACCIDENT & SICKNESS BENEFITS

For Accidents

When Injury, including Injury resulting interscholastic sports (other than interscholastic football, ice hockey or lacrosse), requires treatment, payment will be made up to a maximum benefit of \$2,000, subject to a \$30 deductible, for covered medical expense resulting from each accident occurring during the term insured. Covered medical expenses are those expenses for doctors, surgeons, dentists, hospital confinement, X-rays, laboratory tests, nurses, prescribed medicines, casts, surgical dressings, use of an ambulance, and other Reasonable and Customary medical expense incurred while insured under the Policy. Injuries to sound, natural teeth are covered on the same basis as any other injury. For use of an emergency room a \$50 per visit copay will apply. The \$30 deductible is waived when services are provided at the Student Health Service or when a referral is made by a Student Health Service doctor.

For Sickness

When hospital or medical care is required for sickness including mental and nervous conditions, first manifesting during the term insured, payment will be made as allocated below for covered medical expense not to exceed \$2,000 for any one Sickness under this Benefit. Maternity expense and complications of pregnancy, conception occurring during the term insured, biologically based mental illness/serious emotional disturbances, are covered on the same basis as Sickness. A voluntary or elective abortion is covered only as specifically provided.

Hospital Room and Board Expense: The semi-private room rate, up to \$500 per day when hospitalization is Medically Necessary and ordered by an attending doctor.

Miscellaneous Hospital Expense: Up to \$1,000 for X-ray examinations and laboratory tests, including professional fees, anesthesia, medicines, use of operating room, oxygen tent, drugs (excluding take home drugs), medicines, dressings and other necessary and prescribed miscellaneous hospital expense when the Covered Person is confined as a bed patient in a hospital, or as an outpatient for day surgery.

Pre-Admission Test Expense: Up to \$500 for hospital outpatient expense for tests ordered by a doctor which are required prior to admission as an inpatient for surgery.

Surgeon Expense (in or out of hospital): Up to 80% of Reasonable and Customary charges to a maximum of \$1,500.

Anesthesia: not to exceed 20% of the amount payable for the surgery. **Assistant Surgeon:** not to exceed 20% of the amount payable for the surgery.

Second Surgical Opinion Expense: Up to 5% of the surgical maximum will be paid for a second opinion consultation by a board certified specialist in the medical field related to the surgical procedure to be performed. Payable expense includes X-rays and diagnostic tests.

Doctor's Expense (when hospital confined): Up to \$50.00 per visit for hospital visits, limited to one visit per day. The doctor may not be the surgeon who operated on you.

Doctor's Expense (when not hospital confined): Up to \$50.00 per visit for outpatient services, beginning with the second visit, not to exceed 5 visits, limited to one visit per day. The doctor may not be the surgeon who operated on you. Benefits begin with the first visit if: (1) the student is seen by the Student Health Service and then referred, (2) the sickness is such that emergency treatment is necessary and the Student Health Service is closed or, (3) the student is away from the College for any reason. A \$5.00 per visit copay will apply to conditions 2 and 3. Only one visit per sickness is payable under condition 2.

Consultant Expense: Up to \$125 for the services of a consultant or specialist when such services are deemed necessary and ordered by a Student Health Service doctor, or Athletic Trainer for the purpose of confirming or determining a diagnosis. The attending doctor must order such services for dependents.

Ambulance Expense: Up to \$500.00 for an ambulance when such transportation is required due to the emergency nature of a sickness.

Outpatient Expense: Up to \$500, subject to a \$25.00 deductible, for outpatient X-rays, laboratory tests and the use of an emergency or operating room used for non-scheduled surgeries (the \$25 deductible does not apply to the use of an emergency room; however, a \$50 per visit copay will apply). The \$25 deductible is waived when (1) services are provided at the Student Health Service; (2) a referral is made by a Student Health Service doctor or by an attending doctor for dependents and students when the College is not in session.

CAT Scan, MRI and Similar Procedures: Up to \$1,500 for CAT scans and Magnetic Resonance Imaging when recommended by an attending doctor.

Prescribed Medicine Expense: Up to \$100 per sickness for prescribed drugs and medicines per semester. A \$5 per prescription copay will apply. However obtained, all Outpatient Prescription Drugs are subject to the Outpatient Prescription Drug Maximum.

Dental Expense: Up to \$50.00 per tooth on an inpatient basis and \$25.00 per tooth on an outpatient basis for the removal of impacted wisdom teeth and dental abscesses. No other Policy benefits are payable.

Abortion Expense: Up to \$250 for expense resulting from an abortion, conception occurring during the term insured. No other Policy benefits are payable.

Outpatient Mental and Nervous Conditions Expense: Up to 50% of the charges not to exceed \$30.00 per visit beginning with the third visit, for treatment by a doctor while not hospital confined. Benefits will begin with the first visit if the student is referred by either the Director of Student Health or Director of Counseling. The maximum amount payable under this benefit is \$900 each policy year. (No benefits are paid for prescription drugs related to outpatient treatment of mental and nervous conditions.)

Accidental Death and Dismemberment Indemnity-If the Covered Person sustains any of the following losses as the result of a covered accident, within 26 weeks after the date of accident, the Company will pay the amount shown. "Member" means hand, foot or eye. Loss of a hand or foot means complete severance through or above the wrist or ankle joint. Loss of an eye means the total, permanent loss of sight in the eye. Loss of a thumb or index finger means complete severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand). The Principal Sum of \$7,500 is the largest amount payable under this benefit for all losses resulting from any one accident.

Loss of:	Life.....	\$7,500	One member.....	\$3,750
	Two or more members.....	\$7,500	Thumb and index finger of the same hand.....	\$1,500

Home Health Care Benefit-If the Covered Person requires any of the home health care services listed below as the result of a covered injury or sickness, directly and independently of all other causes, the Company will pay the benefits shown for expense incurred within the policy year. Part-time intermittent nursing care by (or supervised by) a Registered Nurse (R.N.); Part-time or intermittent patient care services by a home health care aide; Physical, occupational, speech, or respiratory therapy provided by a Home Health Care Agency; Medical supplies, drugs and medications, and laboratory services, but only to the extent these benefits would be covered if the patient was confined in a Hospital. The amount of this benefit is 75% of the Reasonable and Customary Charges for the above services made by a Home Health Care Agency, minus a deductible of \$50 per Policy year. This benefit is payable only if the home health care plan is set up and approved in writing by the attending doctor. This benefit will not pay for more than 40 home health care visits in any period of 12 straight months. "Visit" means a maximum of four (4) continuous hours of home health service.

Outpatient Alcoholism and Substance Abuse Expense-The Company will pay for outpatient covered expenses incurred by the Covered Person for the diagnosis and treatment of alcoholism or substance abuse. This benefit covers up to 60 visits in any Policy year for the Covered Person, including up to 20 visits for a Covered Person's family members, if covered under the Policy as dependents. Only one outpatient visit a day is covered. Treatment or services must be provided at a facility in New York State certified by the office of alcoholism and substance abuse services or licensed by such office as outpatient clinics or medically supervised ambulatory substance abuse programs; or, in other states, those facilities accredited by the Joint Commission on accreditation of Hospitals as alcoholism or chemical dependence treatment programs.

Inpatient Care for Alcoholism and Substance Abuse-The Company will pay for the diagnosis and treatment of alcoholism or alcohol abuse and substance abuse or substance dependence, to the extent provided below: (1) For detoxification, inpatient service in a Hospital or Residential Treatment Facility, up to seven days of detoxification treatment in any Policy year, and; (2) For rehabilitation service, up to thirty days of inpatient care in any Policy year. Treatment or service must be provided by a Hospital or Residential Treatment Facility.

Diabetes Equipment, Supplies and Service-The Company will pay the Reasonable and Customary charges incurred for such supplies and service less a deductible of \$25 per Policy year. We will also pay the Reasonable and Customary charges for Diabetes self-management and education.

SUPPLEMENTAL ACCIDENT & SICKNESS BENEFITS

Payment will be made for eighty percent (80%) of covered medical expense incurred for an injury or sickness in excess of \$2,000, to a maximum payment of an additional \$23,000 payable under this Benefit for each accident or sickness. Covered medical expense are those expenses for doctors, surgeons, dentists, hospital confinement, X-rays, laboratory tests, nurses, prescribed medicines, casts, surgical dressings, use of an ambulance, and other Reasonable and Customary medical expense incurred while insured under the Policy.

THIS PROGRAM ALSO COVERS MANDATED BENEFITS AS REQUIRED BY THE STATE OF NEW YORK.

DEFINITIONS

“Accident” means an occurrence which (a) is unforeseen; (b) is not due to or contributed by Sickness or disease of any kind; and (c) causes Injury.
“Totally Disabled” and “Total Disability” means Injury or Sickness which wholly and continuously keeps the Covered Person, (a) with respect to a student, from attending classes at the location where he or she is enrolled; and (b) with respect to a dependent, or a student if such classes are not in session, from doing those activities that are normal for a person in good health of the same age and sex.

“Injury” means bodily injury due to an Accident which: (a) results solely, directly and independently of disease, bodily infirmity or any other causes; (b) occurs after the Covered Person’s effective date of coverage; and (c) occurs while coverage is in force. All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered one Injury.

“Medically Necessary” means that a service or supply is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based on generally accepted current medical practice. A service or supply will not be considered as Medically Necessary if: (a) it is provided only as a convenience to the Covered Person or provider; or (b) it is not the appropriate treatment for the Covered Person’s diagnosis or symptoms; or (c) it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment. The fact that any particular Doctor may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply Medically Necessary, or (d) it can be safely provided to the patient on a more cost-effective basis such as out-patient, by a different medical professional or pursuant to a more conservative for of treatment.

“Pre-Existing Condition” means a Sickness, Injury or condition, whether physical or mental, regardless of its cause, for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the Covered Person’s effective date of coverage under the Policy or a pregnancy existing on the Covered Person’s effective date of Coverage under the Policy. Genetic information shall not be treated as a pre-existing condition in the absence of a diagnosis of the condition related to such information.

“Reasonable and Customary” means the charge which is the smallest of: (a) the actual charge; (b) the charge usually made for a covered service by the provider who furnishes it; and (c) the prevailing charge made for a covered service in the geographic area by those of similar professional standing.

“Sickness” means disease or illness including related conditions and recurrent symptoms of the Sickness. Sickness also includes pregnancy and Complications of Pregnancy. All Sicknesses due to the same or a related cause are considered one Sickness.

COORDINATION OF BENEFITS: Benefits are for Accidents and Sickness are coordinated with other health insurance you may have in force as described in the Policy.

EXCLUSIONS AND LIMITATIONS: The Policy does not cover nor provide benefits for Accident, Sickness, or treatment of a medical condition arising out of: (1) Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of a congenital disease or anomaly of a covered Dependent child which has resulted in a functional defect. It also shall not include breast reconstructive surgery after a mastectomy. This exclusion shall not apply to cosmetic surgery determined, as a result of utilization review and External Review, to be Medically Necessary; (2) Suicide, attempted suicide or intentionally self-inflicted Injury or any attempted intentionally self-inflicted Injury; (3) Travel as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline; (4) Foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet; (5) Care or treatment provided in a government Hospital; benefits provided under Medicare or other governmental program (except Medicaid); (6) Care or treatment for which benefits are provided under any state or Federal Workers’ Compensation, employers’ liability or Occupational Disease Law; (7) A motor vehicle Accident for which benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable; (8) Services rendered and separately billed by employees of Hospitals, laboratories or other institutions; (9) Any services rendered by a Covered Person’s immediate family member; (10) Services for which no charge is normally made; (11) For eyeglasses and examination for the prescription or fitting thereof; (12) Hearing aids and examination for the prescription or fitting thereof; (13) Custodial care and transportation. “Custodial care” means help in transferring, eating, dressing, bathing, toileting, and other such related activities; (14) Rest cures; (15) War or act of war (whether declared or undeclared); (16) Service in the Armed Forces or units auxiliary thereto. Upon the Covered Person entering the Armed Forces or units auxiliary thereto of any country, the Company will refund any unearned pro-rata premium. This does not include Reserve or National Guard Duty for training unless it exceeds 31 days; (17) Participation in a felony, riot or insurrection; (18) Treatment of mental or emotional disorders except as provided under the Policy; (19) Any care or treatment not related to the treatment of Sickness or Injury.

PRE-EXISTING CONDITIONS: Pre-existing conditions are not covered for the first 12 months following a Covered Person’s effective date of coverage under the Policy. This limitation will not apply if: 1) the Covered Person has been covered under the Policyholder’s prior Policy for more than 12 consecutive months; or 2) (a) The individual seeking coverage under the Policy has a total of 12 months of Creditable Coverage and becomes eligible and applies for coverage under the Policy within 63 days of termination of prior Creditable Coverage. We will credit the time the individual was covered under prior Creditable Coverage; and (b) whose most recent prior Creditable Coverage was under an employer group health plan; and (c) who accepted and used up COBRA continuation of coverage or similar state coverage if it was offered to him or her.

EXTENSION OF BENEFITS: If, on the date coverage terminates, a Covered Person is Totally Disabled as a result of Sickness or Injury and is receiving treatment for such Sickness or Injury, benefits will be payable for the Eligible Expenses incurred for that Sickness or Injury after the date coverage terminates until the earliest of the following: (1) the end of the Sickness or Injury that caused the Total Disability; (2) the end of the 90 day period following the date coverage terminated; or (4) the date the applicable Maximum Amount is reached. **IN THE EVENT OF PREGNANCY.** If a Covered Person is pregnant on the date the Policy terminates and the pregnancy commenced while insured while the Policy was in force, benefits will be payable for Eligible Expenses incurred after the Policy terminates until the earliest of: (a) the date the pregnancy ends; (b) the date the Covered Person becomes insured under another policy; or (c) the date the applicable Maximum Amount is reached. The Extension of Benefits will apply only to the extent the Covered Person will not be covered under the Policy or any other health insurance policy in the ensuing term of coverage.

CLAIM PROCEDURE In the event of Accident or Sickness the student should: If at the College, report immediately to Student Health Services so that proper treatment can be prescribed or approved; or if away from the College, consult a doctor and follow his or her advice.

(1) Notify Student Health Services or Maksin Management Corp., within 30 days after the date of the covered accident or commencement of the covered sickness or as soon thereafter as is reasonably possible; (2) Secure a claim form from the Student Health Services or Maksin Management Corp.; (3) Complete the form; (4) Submit the claim form, complete with bills and receipts, to the Student Health Services or Maksin Management Corp.; (5) Submit only one claim form for each accident or sickness. NOTE: Notification of sickness or accident must be furnished within 30 days after the date of accident or commencement of sickness. Bills for which benefit are to be paid must be submitted within 90 days.

Questions regarding enrollment, benefits, a specific claim and periods of coverage should be directed to: Maksin Management Corp. P.O. Box 2647, Camden, NJ 08101-2647 (877) 775-5430 / www.maksin.com	Local Representative: Phelps Agency, Inc. Southern Tier Agency Associates PO Box 1030, Binghamton, NY 13902-1030 Phone: (607) 723-5413 / Fax: (607) 771-0679
---	--

Note: The time you were covered under this program may count as creditable coverage under State and Federal Law if you leave this program and become covered under a group health plan or other plan within 63 days after coverage under the Policy terminates. You are eligible to receive a certification from the Company regarding the periods you were covered. Please contact the Local Representative listed in this flyer when you need such certification.

Annual Premium August 28, 2010-August 27, 2011		Spring/Summer – January 15, 2011-August 27, 2011	
STUDENT	\$ 732.00	\$ 490.00	
SPOUSE	\$1,830.00	\$1,225.00	
CHILD(REN)	\$1,098.00	\$ 735.00	

DISCLAIMER: This is only a brief description of the coverage available under policy series S30494NUFIC. The Policy may contain definitions, reductions, limitations, exclusions and termination provisions. Full details of the coverage are contained in the Policy. If there is any conflict between contents of this document and the Policy, the Policy shall govern in all cases. The Policy is on file for review at Davis College.

It is the Covered Student’s responsibility to maintain continuity of coverage by inquiring about such coverage if he or she has not received the information for the new Policy Year.

**Student Health
Form 3**
Return To:
Student Health
Services



Office Use Only
Re: _____
Sent: _____
Rec. By: _____

Meningitis Information Response Form

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
Form 3**
Return To:
Student Health
Services



Office Use Only
Re: _____
Sent: _____
Rec. By: _____

Meningitis Information Response Form

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.

Return to: Student Health, 400 Riverside Dr., Johnson City, NY 13790 * Phone 607-729-1581 ext. 337 * Fax 607-584-7656
health@davisny.edu 7/10

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: _____

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.

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: _____

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 - 607.584.7656 health@davisny.edu

Student Health
Return To:
Student Health Services



Office Use Only
Re: _____
Ap: _____
Ac: _____

400 Riverside Drive, Johnson City, NY 13790
607.729.1581 ext. 337 • Fax: 607.584.7656 • jjohnson@davisny.edu

Student Health Release Of Information

I _____ Date of Birth _____ Social Security Number _____
Authorize Student Health Services of Davis College to:

Release Obtain (Circle One)

a copy of the following portions of my medical/health record:

- _____ Immunization Record
- _____ Physician's Evaluation
- _____ Personal Medical Report
- _____ Other (please specify) _____

Please **RELEASE** information to:

(Name)

(Address if other than self)

Phone: _____ Fax: _____

Please **OBTAIN** information from:

(Name)

(Address)

Phone: _____ Fax: _____

Received: _____

(Signature)

Sent: _____

(Date)