

Medical Record

HOFSTRA UNIVERSITY

275 Hofstra University
Hempstead, NY 11549-2750

Phone: (516) 463-6745
Fax: (516) 463-5161

TO THE STUDENT: THIS INFORMATION WILL BECOME PART OF YOUR CONFIDENTIAL HEALTH RECORD.

1. Print Name _____ M F
Last First Middle
2. Address _____
Street/Apt. # City State Zip Code
3. Date of Birth _____ Country of Birth _____ Hofstra ID # _____
4. Person to notify in case of emergency _____ Parent Guardian Spouse
Address _____ Phone () _____
Street/Apt. # City State Zip Code
5. Home Phone () _____ Cell Phone () _____
6. Name of Health Insurance Carrier _____ I.D. No. _____
Address of Insurance Company _____ Group No. _____
Subscriber/Cardholder Name _____ Parent Guardian Self Spouse
7. Indicate Student Status: Undergraduate Graduate Law
 Full time Part time
8. Are you a member of an athletic team? If yes, indicate sport. _____
9. Consent for Treatment:

REQUIRED OF ALL STUDENTS OR PARENT/GUARDIAN FOR STUDENTS UNDER THE AGE OF 18:

I, _____, hereby consent to the following:

Hofstra's Health and Wellness Center may hospitalize me (my child) or may perform any medical or surgical procedures or tests deemed necessary in my (my child's) care and treatment. Hofstra's Health and Wellness Center may present information concerning my (my child's) medical condition to other responsible University officials when deemed necessary. Hofstra's Health and Wellness Center may forward any and all of my (my child's) medical records to physicians and/or hospitals when deemed necessary for my (my child's) proper care and treatment.

Signature of Student or Parent/Guardian

Date

10. **REQUIRED BY NEW YORK STATE LAW:
TO BE COMPLETED AND SIGNED BY STUDENT OR PARENT/GUARDIAN FOR STUDENT UNDER THE AGE OF 18.
CHECK ONE ONLY.**

_____ I (my child) had the meningococcal meningitis immunization within the past 10 years. Month ____/ Year ____

_____ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I (my child) will obtain immunization against meningitis within 30 days of the beginning of the semester.

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

Signature of Student or Parent/Guardian

Date

11. **SIGNATURE OF HEALTH CARE PROVIDER IS REQUIRED ON PAGES 3 AND 4.**

12. **Mail completed form in envelope provided to: HOFSTRA UNIVERSITY HEALTH AND WELLNESS CENTER, 275 HOFSTRA UNIVERSITY,
HEMPSTEAD, NY 11549-2750.**

FOR OFFICE USE ONLY

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Name of Student: _____ Date of Birth: _____ Hofstra ID # _____

IMMUNIZATION RECORD

To be completed and signed by health care provider.

New York state law mandates this immunization record be on file prior to registration.

All information must be provided in English.

	MO/DAY/YR	MO/DAY/YR	MO/DAY/YR
*MMR (Measles, Mumps, Rubella) (Two doses with live vaccine required of all persons born after 12/31/56.) History of having measles or documentation of positive measles, mumps, rubella antibody titers			
OR *MEASLES (RUBEOLA) History of having measles, or TWO immunizations with live measles vaccine after first birthday , or documentation of measles antibody titer			
*MUMPS History of having mumps, or immunization with live mumps vaccine after first birthday , or documentation of mumps antibody titer			
*RUBELLA (German Measles) History of having had rubella disease is NOT acceptable! Immunization with rubella vaccine , or documentation of rubella antibody titer			
HEPATITIS B			
DPT			
DT (WITHIN 10 YEARS)			
POLIO (T.O.P.V.)			
MENINGOCOCCAL (one dose)			
VARICELLA			
PPD TUBERCULIN SKIN TEST (REQUIRED REGARDLESS OF PRIOR BCG INOCULATION) Date (within six months): _____ _____ Negative _____ Positive _____ Size of Induration If skin test was positive, the following information is required: Chest X-ray Date _____ Result _____ Treatment given: Date(s) _____ Medication(s) _____			

***required by New York State Department of Health (OTHERS STRONGLY RECOMMENDED).**

I certify that the above-named student has received the immunizations listed above on the dates indicated.

Health Care Provider: _____ Phone No. _____
(PLEASE PRINT.)

Health Care Provider Signature: _____ Date: _____

Health Care Provider Stamp/Office Stamp for Address and Telephone Number: _____