CERTIFICATION OF IMMUNIZATION

Form can also be submitted online at www.hilbert.edu/NextSteps

REQUIRED OF ALL STUDENTS. THIS FORM MUST BE SUBMITTED PRIOR TO START OF CLASS.

STUDENT INFORMATION *(Please print all information)*

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 complete and return this form to Hilbert College.

Name: _____ DOB: _____/_____/_____
Last First M.I.

Gender: ☐ Male ☐ Female

Home Address: _____
Street City State Zip Code

Home Phone: _____ Cell Phone: _____

Group Health Insurance Carrier ID #: _____ Group #: _____

TO THE PHYSICIAN: Please review, complete and date all required immunizations. If records are unobtainable, titer test is necessary for registration at Hilbert College. Titer test results must be sent in with this form.

REQUIRED IMMUNIZATIONS: The following criteria apply to individuals born after 1957.

A. Measles. Two doses with live vaccine after 1967.
   1. First dose (on or after 1st birthday) . . . . . _____ /_____ /_____
   2. Second dose (at least 30 days after 1st dose) . . . . . _____ /_____ /_____
      (or) Physician verified clinical illness . . . . . Year: _____
      (or) Protective Antibody Titer . . . . . Result:_____ Date: _____ /_____ /_____

B. Rubella.
   One dose with live vaccine (on or after 1st birthday) . . . . _____ /_____ /_____
   (or) Protective Antibody Titer . . . . . Result:_____ Date: _____ /_____ /_____
   Note: Previous Clinical Diagnosis of Rubella Is Not Sufficient.

C. Mumps.
   1. One dose with live vaccine (on or after 1st birthday). . _____ /_____ /_____
      (or) Physician verified clinical illness . . . . . Year: _____
      (or) Protective Antibody Titer . . . . . Result:_____ Date: _____ /_____ /_____

(or)
D. Combined M.M.R. (Measles, Mumps & Rubella) . . . . . _____ /_____ /_____ _____ /_____ /_____

PHYSICIAN OR HEALTH CARE PROVIDER:

Signature: _____ Date: _____

Address: _____
Street City State Zip Code

Physician's Office Stamp

FOR MORE INFORMATION

Health Records: Barb DeLaRosa
(716) 649-7900, ext. 123 • bdelarosa@hilbert.edu
Fax: (716) 648-3327

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MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE FORM

Form can also be submitted online at www.hilbert.edu/NextSteps

REQUIRED OF ALL STUDENTS. THIS FORM MUST BE SUBMITTED PRIOR TO START OF CLASS.

RESIDENT STUDENTS MUST HAVE SHOT PRIOR TO MOVING INTO RESIDENCE HALLS.

Required of all students

I am a: ☐ Commuter ☐ Resident Student

Please print all information

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 complete and return this form to Hilbert College.

Student Name: _____ DOB: _____/_____/_____
Last *First* *M.I.*

Check one box and sign below:

Resident students must receive a meningitis immunization.

I have (for students under the age of 18, my child has):

☐ Had the meningococcal meningitis immunization within the past five years. Date _____/_____/_____

received: Physician or healthcare provider signature: _____

☐ 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 (for students under the age of 18, my child will not) obtain immunization against meningococcal meningitis disease.

Students must sign below:

Signature: _____ Date: _____/_____/_____
(Parent/Guardian if student is a minor)

Print Student's Name: _____

*If you have a medical condition that should be reported to the College's Wellness Center please indicate your consent to the Nurse Practitioner contacting you by signing below.

Student Signature: _____

Health Insurance Carrier ID #: _____

Group ID #: _____

Physician's Office Stamp

FOR MORE INFORMATION

Health Records: Barb DeLaRosa

(716) 649-7900, ext. 123 • bdelarosa@hilbert.edu

EMERGENCY CONTACT FORM

Form can also be submitted online at www.hilbert.edu/NextSteps

REQUIRED OF ALL STUDENTS. THIS FORM MUST BE SUBMITTED PRIOR TO START OF CLASS.

Please print all information.

Student Name: _____ DOB: _____/_____/_____
Last *First* *M.I.*

Home Address: _____
Street *City* *State* *Zip Code*

Cell Phone: _____ E-mail: _____

In the event of an emergency or life-threatening situation, please list emergency contact information for person(s) that Hilbert College can contact.

EMERGENCY INFORMATION

Primary Contact

Name: _____ Relationship: _____

Work Phone: _____

Home Phone: _____

Cell Phone: _____

E-mail: _____

Secondary Contact

Name: _____ Relationship: _____

Work Phone: _____

Home Phone: _____

Cell Phone: _____

E-mail: _____

FOR MORE INFORMATION

Health Records: Barb DeLaRosa
(716) 649-7900, ext. 123 • bdelarosa@hilbert.edu

RELEASE OF INFORMATION FOR MENTAL HEALTH

Form can also be submitted online at www.hilbert.edu/NextSteps

OPTIONAL FORM

Please print all information.

Student Name: _____ DOB: _____/_____/_____

If you have a special mental health issue that you would like to disclose to the Hilbert College Counseling Center you may enter that information below or contact the Hilbert Counseling Center directly.

Please check if you have ever had or are currently under treatment for any of the following:

- ☐ Anger Management
- ☐ Eating Disorder
- ☐ Drug/Alcohol Dependency/Abuse
- ☐ Depression
- ☐ Panic/Anxiety Disorder
- ☐ Bipolar Disorder
- ☐ Mood Disorder
- ☐ Obsessive Compulsive Disorder
- ☐ Schizophrenia
- ☐ Deliberate Self-harm
- ☐ Previous Psychiatric Hospitalization
- ☐ Other

Additional Information:

_____

_____

_____

We are here to help you. Assistance is private, confidential and free to all students.

If you will require academic accommodations or adjustments for the above, please sign here:

Signature:_____

FOR MORE INFORMATION

Hilbert College Counseling Center: Phyllis Dewey
(716) 649-7900, ext. 232 • pdewey@hilbert.edu

PHYSICAL EXAMINATION FORM

Form can also be submitted online at www.hilbert.edu/NextSteps

PHYSICALS MUST TAKE PLACE WITHIN THE PRIOR SIX MONTHS OF MOVING IN.
FOR RESIDENT STUDENTS ONLY.

Forms must be submitted prior to move in. Students without completed physicals will not be allowed to move into residence halls. Please print all information.

Student Name: _____ DOB: _____/_____/_____

Gender: ☐ Male ☐ Female

Home Address: _____
Street *City* *State* *Zip Code*

Cell Phone: _____ E-mail: _____

Separate required athletics form can be found at www.hilberthawks.com

Age: _____ Height: _____ Weight:_____ Blood Pressure: _____ Pulse: _____

Build: ☐ Slender ☐ Medium ☐ Heavy Hearing: _____Right_____Left_____

Vision: _____ Color Vision: _____

Hepatitis B Status: _____ Last Tetanus Shot: _____/_____/_____

Other immunizations up-to-date? ☐ Yes ☐ No

List all current medications: _____

Allergies to medications:_____Environmental allergies: _____

Alcohol: ☐ No ☐ Yes _____ day/week/month Smoking: ☐ No ☐ Yes _____ packs per day / _____ years

Check each item in proper column. Enter N/E if not evaluated.

	Normal	Abnormal	Details of each abnormality
Head, Neck, Face, and Scalp			
Nose and Sinuses			
Mouth and Throat			
Teeth and Gingiva			
Ears (perforation of drum, etc.)			
Eyes (lids, conjunctiva, etc.)			
Pupils and Ocular Motion			
Lungs, Chest, and Breasts			
Heart (include estimate of cardiac function)			
Vascular System (varicosities, etc.)			
Abdomen and Viscera (include hernia)			
Ano-rectal (pilonidal)			
Endocrine System			
G-U System			
Upper Extremities (strength, range of motion)			
Feet			
Lower Extremities (as for upper)			
Spine, other Musculo-skeletal			
Skin and Lymphatic			
Neurologic			
Psychiatric (specify and personality deviations noted)			

Continued on back

PHYSICAL EXAMINATION FORM CONTINUED

PAST HISTORY: (DESCRIBE WHEN, WHERE, AND FOR WHAT PURPOSE)

Medical: _____

Surgical: _____

Hospitalizations: _____

CHECK ALL THAT APPLY

Cardiovascular System:
- ☐ Chest pain
- ☐ Dizziness
- ☐ Palpitations
- ☐ Swelling of ankles
- ☐ Hypertension
- ☐ Rheumatic fever
- ☐ Heart murmur
- ☐ Heart racing/skipping beats

Respiratory System:
- ☐ Cough
- ☐ Shortness of breath
- ☐ Pleuritic pain
- ☐ Asthma
- ☐ Hay fever
- ☐ Wheezing

Gastrointestinal System:
- ☐ Nausea
- ☐ Vomiting
- ☐ Pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Jaundice
- ☐ Rectal bleeding
- ☐ Anorexia/bulimia

Hematological System:
- ☐ Tiredness
- ☐ Lethargy
- ☐ Bleeding
- ☐ Bruising
- ☐ Glandular fever
- ☐ Anemia
- ☐ Sickle Cell

Central Nervous System:
- ☐ Head injury
- ☐ Headaches
- ☐ Loss of consciousness
- ☐ Concussion
- ☐ Convulsions/fits
- ☐ Stroke
- ☐ Sleep disturbance

Genitourinary System:
- ☐ One kidney
- ☐ Hematuria
- ☐ Injury
- ☐ Urinary tract infection
- ☐ Sexually transmitted diseases

Menstrual:

Onset: ____ years old

Regular?

☐ Yes ☐ No

If No, how frequent?

_____

☐ Amenorrhea

Birth control?

☐ Yes ☐ No

Is the student able to participate in all physical activities? ☐ Yes ☐ No If no, please indicate: _____

_____

Is there (or has there ever been) evidence of anxiety or emotional instability? ☐ Yes ☐ No

If so, please indicate how the college may be of help to this student: _____

_____

Do you recommend further investigation or treatment? ☐ Yes ☐ No

Physician or Healthcare Provider Signature: _____ Date: _____

Address: _____

Street *City* *State* *Zip Code*

FOR MORE INFORMATION

Health Records: Barb DeLaRosa

(716) 649-7900, ext. 123 • bdelarosa@hilbert.edu

Physician's Office Stamp

ATTENTION ATHLETES

Individuals who are participating in athletics need to complete the athletics online Pre-Participation Process. Please go to ***www.hilberthawks.com****, click on the "Inside Athletics" tab and then click on "Sports Medicine." Once in the sports medicine tab, please scroll to the bottom of the page and click on "***First-year Hilbert student-athletes at Hilbert College.***" Please follow the instructions until you complete all that is required. If you have any questions, contact Greg Peri at gperi@hilbert.edu.*

ACCESSIBILITY SERVICES

Form can also be submitted online at www.hilbert.edu/NextSteps

OPTIONAL FORM

Please print all information.

PLEASE MAIL THIS FORM DIRECTLY TO:

Director, Academic and Accessibility Services
5200 South Park Avenue
Hamburg, New York 14075

In order to receive services/accommodations, students must:

1. Self-identify to the Director of Academic and Accessibility Services.
2. Provide documentation from a qualified professional.
3. Contact the director to schedule a meeting.

Student Name: _____ DOB: _____/_____/_____
Last *First* *M.I.*

Home Address: _____
Street *City* *State* *Zip Code*

Phone: _____ E-mail: _____

Please check all that apply:

☐ Learning Disability ☐ Autism Spectrum Disorder ☐ Chronic Medical Condition
☐ ADD/ADHD ☐ Visual Impairment ☐ Hearing Impairment
☐ Mental Health ☐ Physical Disability ☐ Traumatic Brain Injury
☐ Other Health Impaired: _____

Are you being sponsored by an agency (VA, ACCES-VR, etc.)? ☐ Yes ☐ No

Agency Name: _____

Name of contact person/counselor: _____

FOR MORE INFORMATION

Director of Academic and Accessibility Services: Debbie Dimitrovski
(716) 649-7900, ext. 260 • ddimitrovski@hilbert.edu