**Student Health Center**
**University at Buffalo**
**Buffalo, NY 14214**

## Part 1 – Student Data (to be completed by student)

| | | | | |
|---|---|---|---|---|
| **Patient Name** | Name (last, first, middle) | Phone # | | Social security number |
| **Address** | Number and street | City or town | state | Zip code |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Birth Date** | Month/day/year | **Sex** | Male | Female | **Marital Status** | Married | Single | **Program Of Study** | **GIFTED MATH PROGRAM** | **Country of Birth** | |

Person to be notified in emergency

| | | | | |
|---|---|---|---|---|
| **Name** | First and last name | Relationship | Home and work numbers with area codes | |
| **Address** | Number and street | City or town | State | Zip code |

Primary health care provider

| | | | | |
|---|---|---|---|---|
| **Name** | Agency or physician name | Phone number with area code | | |
| **Address** | Number and street | City or town | State | Zip code |

## PART 2 – Immunization Records (to be filled out by health care provider)

### Measles (Rubeola) Immunity

Students born before 1/1/57 are age exempt

Must have one of the following: month / day / year

| | |
|---|---|
| **1. Two dates of Measles Immunization** (both must be given after 1/1/68 and on or after the first birthday) | # 1: |
| | # 2: |
| **OR 2. Date of measles Titre:** | |
| **Results of Measles Titre:** | ☐ IMMUNE ☐ NON-IMMUNE |

### Rubella (German Measles) Immunity (only valid after 1/1/69)

Must have one of the following: month / day / year

| | | |
|---|---|---|
| **1. One date of Rubella Immunization (given on or after first birthday)** | | |
| **OR** | **2. Date of measles Titre:** | |
| | **Results of Measles Titre:** | ☐ IMMUNE ☐ NON-IMMUNE |
| | *** History of illness not acceptable** | |

### Mumps Immunity (only valid after 1/1/69)

Must have one of the following: month / day / year

| | | |
|---|---|---|
| **1. Date of one Mumps Immunization (given on or after first birthday)** | | |
| **OR** | **2. Date of Mumps Titre:** | |
| | **Results of Measles Titre:** | ☐ IMMUNE ☐ NON-IMMUNE |
| **OR** | **3. Date Physician diagnosed mumps** | |

### Tuberculin Skin Test (PPD Mantoux) Tine not acceptable

Please give all information month / day / year

| | |
|---|---|
| **Date test administered:** | |
| **Result:** | mms |

*** If PPD is not performed state reason and include chest x-ray result and date below:**

### Tetanus Diptheria

month / day / year

| | |
|---|---|
| **(within 10 years)** | |

month / day / year

| | |
|---|---|
| **Hepatitis B Vaccine** (may be required by some programs) | # 1 |
| | # 2 |
| | # 3 |
| **Other Vaccines** | |

**Health Care Provider**

name

address

city state zip

**Health Care Provider: Please sign below after completing information and reviewing for accuracy.**

| | | |
|---|---|---|
| **Health Care Provider Signature** | | date |