St. Bonaventure University
Center for Student Well E H L Q J
Health Services
Phone: 716-375-2310 / Fax: 716-375-7892

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PERSONAL/FAMILY HEALTH HISTORY AND MENINGITIS RESPONSE FORM

For the student: Please complete the following form. It does not need to be signed by your primary care physician.

________________________________, ______________________________, ____________________________________ / ______ / ______

Last Name First Name Middle Name Birthdate

Home Address (Street & No.) City/Town State Zip Gender

6 W X G H Q W ¶ V preferred name/nickname: ________________________ Students Phone #: _________________ Email: _______________________

Emergency Contact Full Name ______________________ Relationship: ______________________ Contact Phone #: ____________________

Do you take any medications daily: Yes or No

If yes, list below: medication name, dosage, and for what condition this is taken (ex: Claritin, 10 mg daily for seasonal allergies). If you need additional room, please list on a separate sheet and attach with form.

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____
____
____

Have you ever had any of the following: Yes or No

Asthma ______ Diabetes _______ Epilepsy _____ Hospitalization ______

Have you ever been diagnosed with COVID-19? , I \ H V S O H D V H O L V W D S S U R [L P D W H G D W H

If ³ < H V ´ to any of the above, please specify: ____

Do you have any P H G L F D W L R Q allergies R U V S H F L D O G L H W D U \ Q H H G V allergies? Please specify W U H D W P H Q W " , I ____________________
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If so, yes to the above do we have your permission to share these needs/restrictions with dining services to ensure that options are available to fit your needs?

Yes ☐ No ☐ Not Applicable

Do you have a family doctor,

FAMILY MEDICAL HISTORY: To help us understand any special circumstances, we need to know if any immediate family members (parents/grandparents/siblings/children) has had any of the following. Please check yes to any that apply and if yes please specify

Blood Diseases: Y N _____

Cancer: Y N _____

Diabetes: Y N _____

Seizure Disorder: Y N _____

HeartDisease: Y N _____

St. Bonaventure University
Center for Student Well E H L Q J

DearStudent/Parent,

As theMedical Director atSt. Bonaventure University

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St. Bonaventure University Center for Student Well E H L Q J

Authorization Form for Medical Treatment and/or Counseling

Please R Q O \ complete this if your child will be **under the age of 18 years while on campus**:

Student Name:____________________ Student DOB:_____________ Student ID#:_____________

Person to notify in the event of an emergency:____

As the parent/guardian of _______________________ S U L Q W V W X G H Q W ¶ V Q D P H , K H U H E \ authorize the medical and counseling staff of St. Bonaventure University & H Q W H U I R U 6 W X G H Q W : H O O E H L Q J to evaluate, advise, perform any diagnostic procedure (on-site or via referral), and/or provide treatment/counseling as deemed advisable and is under the supervision of a licensed medical provider/licensed mental health counselor. I understand that until the student is 18 years of age, I have a right to be informed of this care, except under certain circumstances prescribed by the Medical Practice Act. At the time the student turns 18 years old, he/she will be able to consent to his/her own care and this authorization will no longer apply.