GENERAL REQUIREMENTS:

HEALTH & IMMUNIZATION REQUIREMENTS

Wellness Center – Main Campus, Room 118

Your completed form and supporting document(s) must be uploaded into your CastleBranch account.

For assistance with CastleBranch, please contact Student Support: (888) 723.4263
For assistance with account activation, or to receive your program specific package code, please contact the Wellness Center: (716) 827.2579 | WellnessCenter@trocaire.edu

PART 1: STUDENT DEMOGRAPHICS - To be completed by the student and/ or guardian

STUDENT INFORMATION:

LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH

PREFERRED PHONE	STREET ADDRESS	CITY	STATE	ZIP CODE

EMAIL	STUDENT ID (IF KNOWN)

EMERGENCY CONTACT:

NAME	RELATIONSHIP TO STUDENT	PHONE

MEDICAL HISTORY: Please indicate any health related issues that you would like to make the college aware of.

PART 2: MENINGOCOCCAL/ MENINGITIS RESPONSE FORM - To be completed by the student and/ or guardian

New York State Public Health Law 2167 requires Trocaire to distribute information about meningococcal diseases and vaccinations to all students. Please find this information attached and check the appropriate box below:

☐ I/ my student had a meningococcal immunization within the last 5 years. (**Vaccine record must be submitted**).
Date received: ___ / ___ / _____

☐ I have decided that I/ my student will *not* obtain immunization against meningococcal disease. I/ we have read the attached fact sheet with information regarding meningococcal disease and immunizations. I understand the risks of not receiving the vaccine.

Student Signature: _____ Date: ___ / ___ / _____

Parent/ Guardian Signature (if under 18): _____ Date: ___ / ___ / _____

STUDENT LAST NAME **FIRST NAME** **MIDDLE INITIAL** **DATE OF BIRTH**

PART 3: CORONAVIRUS DISEASE (COVID-19) VACCINATION

Trocaire College requires all currently enrolled students to submit proof of vaccination against Coronavirus Disease into your CastleBranch account. Acceptable forms of immunity are as follows:

(1) Original immunization cards, signed with dates of vaccine(s)
(2) Signed and stamped immunization record from your health care provider or clinic

PART 4: MEASLES, MUMPS, RUBELLA (MMR) - You may submit proof of immunity *or* have information below completed and signed off by your medical provider.

ACCEPTABLE PROOF OF IMMUNITY MAY INCLUDE:

(1) Immunization cards from childhood (yellow card), signed and stamped.
(2) Immunization records from college, high school or other schools you attended.
(3) Signed and stamped immunization record from your health care provider or clinic.
(4) Proof of DD 214 from the armed services within 10 years from the date of application will enable the student to attend school pending actual receipt of the immunization records from the armed services.

MEASLES, MUMPS, RUBELLA (MMR): New York State Public Health Law 2165 requires all students entering a post-secondary institution to provide their health services center with proof of immunity to measles, mumps and rubella. This law applies to students born on or after January 1, 1957, who are registered for 6 or more credits (or its equivalent) regardless of degree or non-degree status at Trocaire College. ***Students born prior to January 1, 1957 are exempt from the measles, mumps, and rubella requirement.***

Please complete one of the options below. Proof of immunity not required if signed off by medical provider below.

Option 1: 1st dose must be given no more than 4 days prior to first birthday; 2nd dose at least 28 days later
Please record month, date, and year of each dose

MMR 1: ___ / ___ / _____ **MMR 2: ___ / ___ / _____**

Option 2:

Measles (Rubeola) Dose 1: **___ / ___ / _____**
Immunized after first birthday

Measles (Rubeola) Dose 2: **___ / ___ / _____**
Immunized at least 28 days after the first dose

Rubella: ___ / ___ / _____ **Mumps: ___ / ___ / _____**

Option 3: Titer Dates (blood test) showing positive immunity (dated lab results ***must*** be attached)

Measles: ___ / ___ / _____ **Mumps: ___ / ___ / _____** **Rubella: ___ / ___/ _____**

_____ _____ ___ / ___ / _____
Provider Name (Printed) Provider Signature Date

_____
Provider Address & Phone