Dear Incoming Student:

It is mandatory that you complete and return the enclosed Cooper Union health forms and the New York State required response forms for Meningitis, and Measles, Mumps and Rubella. **A physician must fill out, sign and stamp the forms. You cannot attend classes until these forms are completed and received.** If you anticipate being involved in athletics, you should attach a statement from the physician declaring that you are fit to participate in athletics.

Please have these forms completed and returned by the deadline, July 1.

Return to:
The Office of Student Affairs
The Cooper Union
29 3rd Avenue, #3B
New York, NY 10003

Questions?
212.353.4130
212.393.4044 fax

Form	Due Date	Status
Personal Medical History	July 1	Mandatory
Physical Examination	July 1	Mandatory
NY Immunization	July 1**	Mandatory
NY Meningitis	July 1**	Mandatory
Disability Identification	July 15*	Optional

* May 1 if it affects dormitory assignment

** **New York State Public Health Law requires all students to submit their Immunization & Meningitis forms. If you do not submit those forms by 5 pm on July 1st 2015, you will be assessed a fee of $100.00. There are no exceptions.**

PERSONAL MEDICAL HISTORY 1 OF 2

MANDATORY

NAME OF STUDENT (PRINT OR TYPE) DATE OF BIRTH

INSTRUCTIONS

All Cooper Union students must complete this medical history and be examined by their personal physician (at student's expense). This is a registration **REQUIREMENT** solely for an evaluation of your health. The Cooper Union will consider the information confidential. Please print clearly and legibly. When you and your physician have completed the form, seal it in the accompanying envelope and mail it immediately.

PERSONAL INFORMATION

Home Address City State Zip

Address while at Cooper City State Zip

Local Telephone E-mail

Emergency Contact Relationship

Home Address City State Zip

Local Telephone E-mail

PERSONAL MEDICAL HISTORY

1. Which of the following illnesses have you had?
   ☐ Diphtheria ☐ Measles ☐ German Measles ☐ Scarlet Fever ☐ Mumps ☐ Chicken Pox ☐ Whooping cough
2. During the past 2 years have you had close contact with anyone having Tuberculosis? ☐ Yes ☐ No
3. Have you ever received any psychological or psychiatric treatment? ☐ Yes ☐ No
4. Do you have an eating disorder? ☐ Yes ☐ No
5. Do you see a dentist regularly (at least once a year)? ☐ Yes ☐ No
   Dentist was last seen on
6. Have you had or do you now have any physical or emotional health problems for which you would like further assistance? ☐ Yes ☐ No
   If yes please explain

(Continued on next page)

PERSONAL MEDICAL HISTORY 2 OF 2 **MANDATORY**

(CONTINUED FROM PAGE 1)

7. What Medications are you currently taking?

8. Is there any reason why you should not participate in all usual college activities? ☐ Yes ☐ No
If yes please explain

LOCAL PHYSICIAN

Please designate a local (i.e., within New York City) physician who will be responsible for your health care while you are attending The Cooper Union.

Name

Address

City State Zip

Telephone Fax

I agree to follow the health and safety procedures and rules established by the Cooper Union and release the Cooper Union from any responsibility for my negligence.

Signature (ALL STUDENTS MUST SIGN) **Date**

MAIL FORM TO:

OFFICE OF STUDENT AFFAIRS
29 THIRD AVENUE, 3B NEW YORK, NY 10003

HAVE QUESTIONS?

212.353.4130
212.353.4044 FAX
COOPER.EDU

THE COOPER UNION
OFFICE OF STUDENT AFFAIRS
STUDENT HEALTH

PHYSICAL EXAMINATION **MANDATORY**

TO BE COMPLETED BY EXAMINING PHYSICIAN

Please give us an assessment based on your previous knowledge of this student's health as well as on your present physical examination. Please review the personal medical history, which has been filled out on the previous page, and correct it where necessary. Please see directions to student on the first page. N.B: Please include notation of medication, dosages, and reports concerning illnesses such as heart disease, asthma, seizure disorders, digestive disease, etc.

NAME OF STUDENT | DATE OF BIRTH | ☐ Male ☐ Female

HOW LONG HAVE YOU KNOWN THIS PERSON?

HEIGHT ft. in. | WEIGHT lbs | PULSE pbm

RESPIRATION / 1 min. | BP / T

THE NEXT THREE ITEMS MUST BE RECORDED. OTHERWISE THE MEDICAL RECORD IS NOT ACCEPTABLE.

1) VISION L /20 · R /20 (UNCORRECTED) | L /20 · R /20 (CORRECTED)

2) URINE

ALBUMIN | SUGAR | OTHER

3a) TUBERCULIN TEST DATE / RESULT | 3b) CHEST X-RAY TEST DATE / RESULT

DATES AND RESULTS OF BOTH ARE REQUIRED IF T.B. TEST IS POSITIVE. TESTS MUST BE PERFORMED NO MORE THAN SIX MONTHS PRIOR TO ENTRANCE.

4) OTHER LAB TESTS

PLEASE CHECK EACH ITEM WHERE APPROPRIATE:

- ☐ Heart Trouble
- ☐ High Or Low Blood Pressure
- ☐ Any Operations
- ☐ Drink Alcohol, Beer, Wine
- ☐ Allergy (Meds, Food, Pollen. Etc.)
- ☐ Liver Disease
- ☐ Infectious Mono
- ☐ Rheumatic Fever
- ☐ Kidney Trouble
- ☐ Diabetes Mellitus
- ☐ Thyroid Or Other Gland Trouble
- ☐ Digestive Disease (Ulcers, Colitis)
- ☐ Lung Disease (Asthma, Tuberculosis, Pneumonia)
- ☐ Fainting, Convulsions, Migraine Headache
- ☐ Blood In Urine Or Stool
- ☐ Smoke (Cigarettes, Cigars, Pot)
- ☐ Eye Trouble
- ☐ Neuro-muscular Disease
- ☐ Difficulty Hearing

Kindly give details, including dates, when possible, for questions answered "Yes". Attach another sheet if necessary.
PLEASE RECORD ALL IMMUNIZATIONS IN THE FOLLOWING CHART. GIVE DATES OF MOST RECENT ADMINISTRATION.

Diphtheria Pertussis/ Teatnus (DPT)	Polio Vaccine Salk: Sabin	Chicken Pox	Hepatitis B	Other

Other

Impression of health status

Is the student receiving or does he or she require medical care, therapy, or observation including maintenance medications?
☐ Yes ☐ No (If "Yes" please explain)

Examining Physician | **MD/DO** | **Date of Exam** | **Physician's Stamp**

PHYSICIAN'S SIGNATURE | PLEASE STAMP CLEARLY

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THE COOPER UNION
OFFICE OF STUDENT AFFAIRS
STUDENT HEALTH

IMMUNIZATION FORM

NEW YORK STATE MANDATORY

NAME OF STUDENT (PRINT OR TYPE) **DATE OF BIRTH**

New York State Public Health Law (NYS PHL2165) requires post-secondary students to show protection against measles, mumps and rubella. Persons born prior to January 1, 1957 are exempt from this requirement. **You must have two measles shots.**

If you cannot provide proof of your having the required vaccinations, you must provide results from a titer (blood test) proving your immunity to the disease.

REQUIRED: MEASLES (RUBEOLA) IMMUNITY— MUST HAVE ONE OF THE FOLLOWING:

1. Two dates of Measles Immunization: (1) (2)

Both must be given after 1967. The first immunization must be on or after the first birthday and the second on or after 15 months of age.

2. Date of Measles Titer: Results:

3. Date of physician diagnosed measles

AND the signature of the diagnosing physician

REQUIRED: RUBELLA (GERMAN MEASLES) IMMUNITY — MUST HAVE ONE OF THE FOLLOWING:

1. Date of at least one Rubella Immunization: (1) (2)

Must be on or after the first birthday.

2. Date of Rubella Titer: Results:

Physician diagnosis is not acceptable.

REQUIRED: MUMPS IMMUNITY — MUST HAVE ONE OF THE FOLLOWING:

1. Date of at least one Mumps immunization: (1) (2)

The Cooper Union recommends that students entering school in fall 2014 provide proof of a second mumps vaccination. We anticipate that the New York State law will change to require this in the near future.

2. Date of Mumps Titer: Results:

3. Date of physician diagnosed mumps disease:

PLEASE NOTE: MMR vaccine is recommended for all measles vaccine doses to provide increased protection against all three vaccine-preventable diseases: measles, mumps, and rubella.

Signature of Health Practitioner **Physician's Stamp**

MAIL FORM TO:

OFFICE OF STUDENT AFFAIRS
29 THIRD AVENUE, 3B
NEW YORK, NY 10003

HAVE QUESTIONS?

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COOPER.EDU

MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE

NEW YORK STATE MANDATORY

Dear Parents and Students,

New York State Public Health Law (NYS PHL 2167) requiring institutions, including colleges and universities, to distribute information about meningococcal disease (meningitis) and vaccine information to all students meeting the enrollment criteria, whether they live on or off campus. Cooper Union is also required to maintain a record of the following for each student taking more than six credits in a given semester:

THE RECORD CONSISTS OF:

Response to receipt of meningococcal meningitis disease and vaccination information, signed by the student or a parent or guardian	**AND**	**A record of meningococcal meningitis immunization within the past 10 years** **OR** **An acknowledgement of meningococcal disease risks and refusal of meningococcal meningitis immunization signed by the student or parent or guardian**

Meningitis is rare. However, when it strikes, its flu like symptoms make diagnosis difficult. If not treated early, meningitis can lead to swelling of the fluid surrounding the brain and spinal cord, seizures, limb amputation and even death.

Cases of meningitis among teens and young adults 15 to 24 years of age (the age of most college students) have more than doubled since 1991.

The disease strikes about 3,000 Americans each year and claims about 300 lives. Between 100 and 125 cases of meningitis occur on college campuses and as many as 15 students will die from the disease. A vaccine is available that protects against four types of the bacteriathat cause meningitis in the United States: types A, C, Y and W-135. These types account for nearly two thirds of meningitis cases among college students.

Cooper Union does not offer meningococcal meningitis vaccinations:

You may find a physician or office near you that stocks the vaccine by consulting www.nmaus.org.

Please complete the Meningococcal Meningitis Vaccination Response Form and return it to the Office of Student Services. Even if you have provided proof of vaccination already, you will still need to return this form.

You can also find information about the disease at:

New York State Dept. of Health
www.health.state.ny.us

Center for Disease Control and Prevention
www.cdc.gov/ncidod/dbmd/diseaseinfo

ACHA
www.acha.org

MAIL FORM TO:

OFFICE OF STUDENT AFFAIRS
29 THIRD AVENUE, 3B NEW YORK, NY 10003

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THE COOPER UNION
OFFICE OF STUDENT AFFAIRS
STUDENT HEALTH

MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE

NEW YORK STATE MANDATORY

NAME OF STUDENT (PRINT OR TYPE) DATE OF BIRTH

PLEASE NOTE: THE NEW YORK STATE PUBLIC HEALTH LAW REQUIRES THAT IF THE STUDENT IS UNDER THE AGE OF 18, THE PARENT OR GUARDIAN **MUST** SIGN THIS FORM AS WELL.

CHECK ONE BOX AND SIGN BELOW

☐ I had the meningococcal meningitis immunization (Menomune) within the past 10 years

Date received

Note: The vaccines protection lasts for approximately 3 to 5 years. Revaccination may be considered within 3-5 years.

☐ I read, or have had explained to me, the information regarding meningococcal meningitis disease. I will obtain immunization against meningococcal meningitis within 30 days from my health care provider.

☐ I 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 I will not obtain immunization against meningococcal meningitis disease.

Signed student Date

Signed parent/guardian, if student under 18 Date

Student's Name print clearly Date of Birth

Student ID

Home Address City State Zip

Telephone E-mail

MAIL FORM TO:

OFFICE OF STUDENT AFFAIRS
29 THIRD AVENUE, 3B
NEW YORK, NY 10003

HAVE QUESTIONS?

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THE COOPER UNION
OFFICE OF STUDENT AFFAIRS
STUDENT HEALTH

SELF-IDENTIFICATION FORM
FOR STUDENTS WITH DISABILITIES

NAME OF STUDENT (PRINT OR TYPE) | DATE OF BIRTH

PRESENT ADDRESS | CITY | STATE | ZIP

☐ Architecture ☐ Art ☐ Engineering

SCHOOL | TELEPHONE | EMAIL

If you are a student with a disability, you are urged to fill out this form and attach supporting documentation, including a letter from your physician describing your condition and what accommodations you may need to succeed in college. Supporting documentation should be recent (less than a year old). Your response is voluntary. The information will be kept in a confidential file by the Office of Student Services, accessible to those with a legitimate need for access to the information.

Your main contact will be the Office of Student Services. They will work with your academic advisor to resolve problems and arrange accommodations needed for access to your program of study and to student activities. Readers, signers, special laboratory equipment and coordination with faculty in making accommodations in course work or examinations are examples of the kinds of arrangements that can be made. Because these adjustments take time, we ask that you submit this form as soon as possible, and in no case later than July 15, for the following fall semester.

1. What is the nature of your disability?

2. Do you need accommodations to perform your course or laboratory work satisfactorily or safely?

3. Please describe each accommodation you think you need. Your documentation should support these requests.

PLEASE ATTACH YOUR SUPPORTING DOCUMENTATION FROM YOUR PHYSICIAN AND RETURN THIS FORM TO THE OFFICE OF STUDENT SERVICES, 29 THIRD AVENUE, NEW YORK, NY 10003, NO LATER THAN JULY 15.

MAIL FORM TO:

OFFICE OF STUDENT AFFAIRS
29 THIRD AVENUE, 3B
NEW YORK, NY 10003

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