

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.

You cannot attend classes until these forms are completed and received.

Forms should be completed and uploaded through the applicant portal no later than **Friday, December 13, 2024.**

Questions?

healthforms@cooper.edu

212.353.4130

Form	Due Date	Status
Personal Medical History	December 13	Mandatory
Physician Medical Clearance	December 13	Mandatory
NY Immunization	December 13*	Mandatory
NY Meningitis	December 13*	Mandatory
Emergency Action Plan	December 13	Mandatory
Disability Identification	December 13	Optional

* New York State Public Health Law requires all students to submit their Immunization & Meningitis forms.

IMPORTANT NOTES:

All forms must be submitted and complete by December 13, 2024. All forms received after December 13, 2024, will automatically be assessed a \$100 late processing fee.

Students cannot be registered for classes and cannot access any Cooper Union facilities, including our Student Residence Hall, until these forms are completed. Fall semester course registration for new students is automatic but will be withdrawn for students who have not submitted their completed health form packet. Not completing these forms by the required deadline may have implications for course registration and availability. Students will not be permitted to attend an in-person courses in the summer unless the entire health form packet has been received and is completed.

Late forms can result in course registration complications and may result in the loss of an offer for on-campus housing.

NAME OF STUDENT (PRINT OR TYPE)

DATE OF BIRTH

Male Female Trans Non-Binary Other _____

INSTRUCTIONS

All Cooper Union students must complete this medical history. 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 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		

*your local address (while at Cooper) should be updated if it changes before or during your time at Cooper

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
 Depression Anxiety Bi-Polar Disorder Schizophrenia Suicide Attempts Other _____
4. Do you have an eating disorder? Yes No

Please check each item where appropriate. Kindly give details, including dates, when possible. Attach a separate sheet if necessary.

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

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5. As a Cooper Student, you are required to have health insurance. Who is your health insurance provider and does your insurance work in New York state? If you are unsure, it is best to talk with your insurance provider before arriving to better understand your policy. Cooper Union does offer students health insurance through Wellfleet. More information about Wellfleet, as well as cost for a policy, can be found by visiting www.cooper.edu/studenthealthinsurance.

6. Do you have a Primary Care Provider? If so, please list their office info (name, address, phone, etc.).

7. Do you have a therapist or psychiatrist? If so, please list their office info (name, address, phone, etc.).

8. What medications are you currently taking?

9. Is there any reason why you should not participate in all usual college activities? Yes No

If yes please explain

I understand that The Cooper Union is a small specialized elite institution focusing on Art, Architecture, and Engineering. Located in New York City, The Cooper Union does not have any on-campus health center nor does The Cooper Union provide access to on-going mental health services. I further understand that The Cooper Union assists students in locating local resources for their physical and mental health care, but students are required to function independently and must be able to manage their mental and physical healthcare related issues. 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

Parent's Signature (IF THE STUDENT IS UNDER THE AGE OF 18)

Date

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: Immune Not Immune
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: Immune Not Immune
Physician diagnosis is not acceptable.

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

1. Date of at least one Mumps immunization: (1) _____ (2) _____
Must be on or after the first birthday.
2. Date of Mumps Titer: _____ Results: Immune Not Immune
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

NAME OF STUDENT (PRINT OR TYPE)

DATE OF BIRTH

This form MUST be completed by a licensed physician prior to beginning studies at The Cooper Union. If a student takes a medical or personal leave of absence at any point in their career they need to resubmit this form prior to reengaging with their studies.

Are there any emotional, mental, or physical conditions for which this student is under medical observation and care and/or taking any medication? Yes No

If yes, please specify condition(s) and indicate any relevant details. Please attach any relevant and/or necessary documentation to this form:

Physician recommendation for student engagement in extra-curricular activities:

Full Engagement without Restrictions Limited Engagement with the Following Restrictions

Restrictions are as follows:

MEDICAL CERTIFICATION

The physician noted below hereby certifies that the above-named student is emotionally, mentally, and physically able to engage in a rigorous and academically demanding course of study at The Cooper Union for the Advancement of Science and Art in New York City.

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The student named above has been examined by me and it is my opinion that they are emotionally, mentally, and physically able to engage in studies at The Cooper Union.

Name of Physician Printed

Physician Phone Number

Physician Address

Physician's Stamp

Physician Signature

Dear Parents and Students,

Late in the summer of 2003, Governor Pataki signed 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 bacteria that 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 nmaus.org.

Please complete the Meningococcal Meningitis Vaccination Response Form and return it to the Office of Student Affairs. 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
health.state.ny.us

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

ACHA
acha.org

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 ONLY ONE BOX AND SIGN BELOW

I had the meningococcal meningitis immunization within the past 10 years

Date received

Note: The vaccine's 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

NAME OF STUDENT (PRINT OR TYPE)

DATE OF BIRTH

The Cooper Union is a small, specialized institution offering professional degrees in Art, Architecture, and Engineering, located in New York City. Given the recent history with COVID-19 and other work occurrences, we believe it is important for our students to be prepared for emergency situations, should one occur. An emergency may be a personal physical or mental health crisis and/or larger incidents that could impact The Cooper Union.

Should a student need to immediately be temporarily separated from Cooper Union due to an ongoing health emergency or national/global crisis, we want students to make sure that they have an action plan in place. It is important to have these conversations with parents/guardians before it is needed and before arriving at The Cooper Union.

All students (those planning to live in our student residence hall, in a private apartment off-campus, or with a parent/guardian) are asked to think about, consider, and plan for a potential emergent situation.

Please return this document to the Office of Student Affairs along with your medical history forms.

Emergency Contact Name(s): _____

Emergency Contact Phone Number(s): _____

Emergency Contact Email Address(es): _____

Emergency Contact(s) Relationship to you: _____

ACTION PLAN

We want to know what your plan is. Please describe in detail below (or attach a separate sheet if you need more space) what your plan would be if The Cooper Union were to close immediately due to an emergency/national/global crisis and/or if you were to suffer a personal physical or mental health emergency and are unable to safely remain at The Cooper Union.

1. Where would you go? Be very specific.

2. How will you get there? (Drive, fly, someone will pick you up, etc.)

3. What do you need to take with you when departing (the most essential items)?

NAME OF STUDENT (PRINT OR TYPE)

DATE OF BIRTH

PRESENT ADDRESS

CITY

STATE

ZIP

Art Architecture 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 disability 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 Affairs, accessible to those with a legitimate need for access to the information.

While we absolutely provide reasonable accommodations to students with disabilities, we want all students to be aware that the expectations at Cooper are very high and our programs and courses are extremely rigorous and move very quickly. The speed at which our curriculum advances is rapid and the rigor and intensity of our academics are fundamental components of how we teach and how students progress through our degree programs. Our courses are challenging for all of our students and any reasonable accommodations that are provided will not alter the expectations of our students and rigor of our courses.

We take an individualized approach to disability accommodations understanding that each student is unique and how they engage with our coursework is also unique. The Office of Student Affairs will be in contact with any student who completes this form to review your specific needs and establish a plan.

Your main contact will be the Office of Student Affairs. 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, ideally no later than December 15.

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 INCLUDE YOUR SUPPORTING DOCUMENTATION FROM YOUR PHYSICIAN AND RETURN THIS FORM TO ALEX FISCHER, DIRECTOR OF STUDENT CARE & SUPPORT, VIA EMAIL - ALEX.FISCHER@COOPER.EDU OR DISABILITY@COOPER.EDU.