Dear Incoming Paul Smith's Student,

Student Health Services would like to welcome you to Paul Smith's College. For the next two to four years, we will be your resource for any health care needs that arise. To best serve those needs, it is imperative that we obtain a good baseline on your health prior to the start of classes.

We therefore require that the attached health information packet be completed and turned in prior to the first day of classes. This information is confidential and protected by HIPAA (Health Insurance Portability and Accountability Act). To ensure the protection of your personal information and its timely arrival to our office, please send us this packet in an envelope marked CONFIDENTIAL, and addressed to Student Health Services. Your health information should not go to any other office.

Failure to complete and submit the required paperwork prior to the start of classes result in negative consequences, such as: refusal of care, a barring from classes, a hold on registration for the next semester, and /or exclusion from campus. If there is a stumbling block to completion of this packet, please contact the Health Service Office as soon as possible to discuss how best to proceed.

It is important to note that currently, during the summer months, Health Services is not staffed daily. We do our best to monitor and return any messages left on voicemail or e-mail at the office, however, to avoid delays in answering any questions you might have, additional contact numbers have been provided. If you do not hear back from our office within 24 hours after you have left a message, please use the cell or home number listed.

We look forward to hearing from you and getting to know you over the next few years. Please do not hesitate to be in touch at any time during the entry process or as you progress through your degree.

Respectfully,

Reiko Rexilius-Tuthill, RN, BSN
Director Student Health Services
Paul Smith's College
rrexilius@paulsmiths.edu
Work Phone: 518-327-6349
Fax: 518-327-6309
Cell Phone: 518-524-3691
Home Phone: 518-891-3820

Abigail Bailey
Administrative Assistant- Student Health Services
Paul Smith's College
abaileystaff@paulsmiths.edu
Work Phone: 518-327-6319
Fax: 518-327-6309

*Please remember to use the envelope provided to ensure we receive your health information at Student Health Services and that it remains "*confidential*".

Student Health Services
P.O. Box 265
Routes 86 & 30
Paul Smiths, NY 12970

Student Name: _____ DOB: _____

At the Paul Smith's College Student Health Service Office, located downstairs in the Joan Weil Student Center, we are committed to providing high quality medical care to all students. The following are highlights of some of the services that Health Service provides:

- RN on site Monday – Friday (8:30 am- 3:30 pm) for assessment, treatment and education
- Primary care providers M-W-F (10 am- 12pm) for diagnosis and treatment
- Frequently used OTC medications and supportive devices
- On-site lab services (blood draw, Rapid test for Mono, Strep A, Pregnancy, Urinalysis, Influenza)
- Reproductive health care needs
- Allergy serum administration
- Nebulizer treatments
- Sports Physicals
- Confidential HIV and STD testing and counseling
- Glucose testing
- Blood Pressure screening and data collection
- Vision testing for Driver License renewal
- Smoking cessation counseling
- Nicotine Replacement Therapy
- Immunization administration (Hep A, Hep B, Meningitis, Tdap, MMR, HPV)
- Tuberculosis screening and treatment when necessary- PPD
- Prescription processing (Post Office Pharmacy in Saranac Lake, NY 518-891-2233)
- Coordination of care with other specialty offices and/or hometown practitioners
- Coordination of Care with Student Counseling Center (SCC) as necessary

The Nurse will see students on a first come, first serve basis, unless there is a medical issue which in her professional opinion becomes a priority. If after triage and/or treatment by the Nurse, further evaluation is appropriate, appointments will be made for medical evaluation by a Physician or Physician Assistant. Every effort is made to consider the student's schedule, severity of health concern, and availability of Physician or Physician Assistant. If a medical need is great enough to warrant immediate attention and it is not doctor hours, attempts will be made to move the student into an appointment with Medical Associates in Saranac Lake, or a referral to the ER or Urgent Care will be made, or an ambulance called.

There is no out of pocket cost to be seen by the nurse or medical representative at Student Health Services. This is covered in the Health Service Fee listed on your student account. Many of the above mentioned items are available at no cost; though some may have a nominal fee. Any fee encored, is placed on the student account as an *infirmary charge* to avoid any out of pocket expense to the student and to encourage best practice by the student for treatment of their health care needs.

Student Health Services • Phone: (518) 327-6319 • Fax: (518) 327-6309
PO Box 265 • Paul Smith's College • Paul Smiths, NY 12970 • www.paulsmiths.edu

Please print or type all information in this packet.

Demographics, Emergency Contacts, and Permission to Treat:

Student Name: _____ DOB: _____

Date of Entry/Semester: Fall_____ or Spring _____ Area of Study/Major: _____
YEAR YEAR

Name: _____ DOB: _____ Age: _____
Gender: □ Male □ Female □ Gender Neutral Student SSN: _____
Home Address: _____
Street City State Zip

Home Phone: (____) _____ Cell Phone: (____) _____
Primary Care Provider: _____
Phone: _____ Fax: _____
Address: _____
Street City State Zip

INSURANCE

***PLEASE ATTACH A FRONT/BACK COPY OF YOUR HEALTH INSURANCE CARD**

□ Private Insurance* □ College Insurance □ Both

Primary Insurance: _____
Insurance ID #:_____ Insurance Group #:_____
Subscriber's Name: _____ Subscriber's DOB: _____
Subscriber's SSN: _____Relationship to student: Mother/Father/Guardian/Spouse/Self

To accept or to decline college insurance, you must do so online at **gallagherkoster.com**

PERMISSION TO TREAT

I, the undersigned, authorize Paul smith's College Student Health Services, nursing/medical staff, to provide care for any illness or injury occurring while I am enrolled at PSC.

Student Signature: _____ Date: _____

***Parent/Guardian: _____ Date: _____**

***If student is under 18 years of age a signature is required by both the student and parent/guardian.**

EMERGENCY CONTACT

Contact #1:_____
Relationship to student: Mother/Father/Guardian/Spouse
Address: _____
_____
Home Phone: (_____) _____
Work Phone: (_____) _____
Cell Phone: (_____) _____

Contact #2: _____
Relationship to student: Mother/Father/Guardian/Spouse
Address: _____
_____
Home Phone: (_____) _____
Work Phone: (_____) _____
Cell Phone: (_____) _____

In case of emergency, I, the undersigned, give authorization for SHS to contact the above mentioned individuals.

Student Signature: _____ Date: _____

***Parent/Guardian: _____ Date: _____**

***If student is under 18 years of age a signature is required by both the student and parent/guardian.**

Student Name: _____ DOB: _____

PAUL SMITH'S COLLEGE

SHARING INFORMATION:

Student Health Services takes all reasonable precautions to ensure privacy with regards to your medical information. However, there will be times where it is necessary to share information. Please initial beside each and sign below to indicate an understanding that in the following circumstances, information will be shared:

_____ An up to date, yearly physical is required by all sport teams and sport clubs. Proof of physical or lack thereof, will be shared between Student Health Services and the athletic director and/or coach/club representative.

_____An acute medical condition, such as illness or injury, may require communication between Student Health Services and the Athletic Director, Trainer, Coach(s), or club representative, to ensure continuity of care and safest practice is exercised by all.

_____A medical condition, temporary or permanent, may require communication between Student Health Services and Accommodative Services for the purpose of academic assistance/accommodation.

_____The Counseling/Student Development Center functions under the same health care umbrella as Student Health Services and therefore, information may be shared, as necessary, for treatment purposes.

_____ In case of a health care emergency, your designated emergency contact will be notified.

_____ In the event that you are admitted to the local ER and unable to communicate, Student Health Services will relay pertinent information such as allergies, insurance, medical conditions, and or medications to the medical representative of the ER.

_____ Health Services must abide by the NYS SAFE Act, which allows law enforcement to restrict access to firearms for those who pose a serious danger to themselves or others.

_____ If student health records are subpoenaed by the court for a legal case, then information will be shared.

_____ If abuse is suspected of a child or elder- neglect or maltreatment, information would be shared as necessary to protect those involved.

_____ If you pose a threat to yourself or others; potential suicide or homicide, then information will be shared.

_____ It is recommended that those with food allergies stop by the Dining Hall upon arrival to campus and introduce themselves to the food service staff; letting them know what allergies or special dietary needs they may have.

Student Signature: _____ Date: _____

***Parent/Guardian: _____ Date: _____**
***If student is under 18 years of age a signature is required by both the student and parent/guardian.**

Student Name: _____ DOB: _____

PAUL SMITH'S COLLEGE

HEALTH HISTORY

TO BE COMPLETED PRIOR TO DR. APPOINTMENT

ALLERGY					
DRUG	□ Y □ N	FOOD	□ Y □ N	ENVIRONMENTAL	□ Y □ N

MUSCULOSKELETAL		SKIN		RESPIRATORY	
ARTHRITIS	□ Y □ N	ACNE	□ Y □ N	ASTHMA	□ Y □ N
BROKEN BONE(S)	□ Y □ N	ECZEMA	□ Y □ N	CYSTIC FIBROSIS	□ Y □ N
SCOLIOSIS	□ Y □ N	PSORIOSIS	□ Y □ N	SLEEP APNEA	□ Y □ N
CHRONIC PAIN	□ Y □ N	SHINGLES	□ Y □ N	POSITIVE PPD	□ Y □ N
TENDONITIS	□ Y □ N	SKIN CANCER	□ Y □ N	TB TREATMENT	□ Y □ N
OTHER	□ Y □ N	OTHER	□ Y □ N	OTHER	□ Y □ N

NEUROLOGY		CARDIAC		RENAL	
SEIZURES	□ Y □ N	A-FIB	□ Y □ N	KIDNEY STONE(S)	□ Y □ N
MIGRAINE	□ Y □ N	BRADYCARDIA	□ Y □ N	KIDNEY INFECTION(S)	□ Y □ N
PARALYSIS	□ Y □ N	TACHYCARDIA	□ Y □ N	KIDNEY FAILURE	□ Y □ N
CONCUSSION(S)	□ Y □ N	HEART MURMUR	□ Y □ N	ONE KIDNEY	□ Y □ N
VISION LOSS	□ Y □ N	ABNORMAL RHYTHM	□ Y □ N	KIDNEY TRANSPLANT	□ Y □ N
HEARING LOSS	□ Y □ N	RHEUMATIC FEVER	□ Y □ N	POLYCYSTIC KIDNEY	□ Y □ N
SPEECH IMPEDIMENT	□ Y □ N	HIGH BLOOD PRESSURE	□ Y □ N	UTI	□ Y □ N
OTHER	□ Y □ N	OTHER	□ Y □ N	OTHER	□ Y □ N

ENDOCRINE		MEN		GASTROINTESTINAL	
DIABETES I	□ Y □ N	N/A	□ Y □ N	GALL BLADDER	□ Y □ N
DIABETES II	□ Y □ N	HYDROCELE	□ Y □ N	HERNIA	□ Y □ N
THYROID	□ Y □ N	UNDESCENDED TESTICLE	□ Y □ N	IBS	□ Y □ N
OSTEOPEROSIS	□ Y □ N	VARICOCELE	□ Y □ N	GERD(REFLUX)	□ Y □ N
OBESITY	□ Y □ N	LUMP OR MASS	□ Y □ N	CHRON'S/COLITIS	□ Y □ N
OTHER	□ Y □ N	STD	□ Y□ N	LIVER DISEASE	□ Y □ N
		OTHER	□ Y □ N	OSTOMY	□ Y □ N
				OTHER	□ Y □ N

PSYCHIATRIC		BLOOD/LYMPH/CANCER		WOMEN	
ANXIETY	□ Y □ N	ANEMIA	□ Y □ N	N/A	□ Y □ N
ADHD	□ Y □ N	DVT/BLOOD CLOT	□ Y □ N	CANCER	□ Y □ N
DEPRESSION	□ Y □ N	SICKLE CELL ANEMIA	□ Y □ N	LUMP OR MASS	□ Y □ N
CUTTING	□ Y □ N	LYMPHOMA	□ Y □ N	FIBROCYSTIC	□ Y □ N
EATING DISORDER	□ Y □ N	HEMOPHILIA	□ Y □ N	PELVIC INFLAMMATORY	□ Y □ N
ADDICTION	□ Y □ N	HIV/AIDS	□ Y □ N	MENSES ISSUE	□ Y □ N
OCD	□ Y □ N	HIGH CHOLESTEROL	□ Y □ N	STD	□ Y □ N
PSYCH HOSPITALIZATION	□ Y □ N	OTHER	□ Y □ N	OTHER	□ Y □ N
OTHER	□ Y □ N				

PLEASE ELABORATE BELOW ON ANY BOX CHECKED **YES**. GIVE DATE, MEDICATION AND/OR TREATMENT ASSOCIATED WITH THE CONDITION._____

_____

_____

_____

Student Name: _____ DOB: _____

CLINICAL EVALUATION

(To be no older than 3 months prior to date of entry)

□ Health History (back) reviewed with the patient to ensure completeness and accuracy.

Height: _____ Weight: _____ Blood Pressure: _____/_____ Pulse: _____ Temp: _____

Vision: Uncorrected Corrected (Glasses or Contacts)
Right: 20/_____ 20/_____
Left: 20/_____ 20/_____

Hearing:
Right: _____ ○ Aid
Left: _____ ○Aid

General	Normal	Abnormal	Details
HEENT			
Heart			
Lungs & Chest			
Vascular System			
Abdomen			
Skin			
Upper Extremities			
Lower Extremities			
Spine & Musculoskeletal			
Neurologic			
Psychiatric			
Genitourinary			[ ] Not done
Anorectal			[ ] Not done

Does the student use tobacco product(s), alcohol, or illegal drugs?
If so, please specify type and quantity: _____

Does the student have a disability- physical or cognitive, which may require special arrangements?
If so, specify and send supportive documentation: _____

Please list current medications; specify condition being treated, dose/ frequency/route:
_____
_____

In your opinion, is this patient/student physically able to participate in intercollegiate athletics?
[ ] Yes [ ] No
If not or there is a limitation, please explain_____

In your opinion, is this patient/student able to meet the physical and emotional demands of college life?
[ ] Yes [ ] No
If not or there is a limitation, please explain: _____

Provider's Name: _____ _____
Print

Provider's Signature: _____ Date: _____

Address: _____
Street City State Zip

Phone: (____) _____ Fax: (____) _____

Student Name: _____ DOB: _____

PAUL SMITH'S COLLEGE

IMMUNIZATIONS

MMR -measles/mumps/rubella: (State mandated to attend college)

MMR #1:_____ MMR# 2: _____ OR

Measles Titer*: _____ Mumps Titer *: _____ Rubella Titer*: _____ OR

*Attach copy of titer report to this form.

MD Diagnosis of Disease: Measles_____ Mumps_____ Rubella_____

PPD: (Required within a year prior to entry for all students)

Date Administered: _____ Date Read: _____ Results: POS/NEG _____mm

If positive PPD: If positive Gold Test:

Gold Test results: _____ Treatment method &dates: _____

Meningitis: (Required if resident student)

Menactra/ Menomune/Menveo: _____ Booster: _____

Note: Persons aged 21 years or younger should have documentation of receipt of a dose of meningococcal conjugate vaccine not more than 5 years before enrollment. Anyone 19-55 years of age should be vaccinated against meningococcal if living in the dorms

Hepatitis A Series: (Required if Major in RATE/Culinary/Baking/Hospitality Resort Management)

Hep A #1: _____ Hep A #2: _____

Tetanus/Diphtheria/Pertussis: (Recommended)

Childhood Series: # of doses _____ Date completed: _____ TD or Tdap booster:_____

Varicella: (Recommended)

Varicella #1:_____ Varicella #2: _____ MD diagnosed disease: _____

Hepatitis B Series: (Recommended)

Hep B #1: _____ Hep B #2: _____ Hep B #3: _____

Polio: (Recommended)

Childhood Series # doses: _____ Date of Completion: _____

HPV Series: (Recommended)

HPV #1: _____ HPV #2: _____ HPV #3: _____

Other Vaccines:

_____ _____ _____ _____

Student Name: _____ DOB: _____

MENINGOCOCCAL VACCINATION RESPONSE FORM

New York State Public Health Law requires that all college and university students enrolled for at least six (6) semester hours or equivalent, or at least four (4) semester hours per quarter, must complete this form.

Student Health Services carefully tracks whether this form is returned. Students without a copy of it in their file prior to 30 days after the start of classes will be excluded from campus.

I certify that:

☐ I had the meningococcal meningitis immunization (Menomune™ , Menactra™ or Menveo)

- Date given: _____
- **Note: Persons aged 21 years or younger should have documentation of receipt of a dose of meningococcal conjugate vaccine not more than 5 years before enrollment. Anyone 19-55 years of age should be vaccinated against meningococcal if living in the dorms.**

☐ I have read, or have had explained to me, the information regarding meningococcal meningitis disease.

- The student will obtain the immunization against meningococcal meningitis prior to starting college.

☐ I have read, or have had explained to me, the information regarding meningococcal disease.

- The risks of not receiving the vaccine are understood.
- I decline to obtain immunization against meningococcal meningitis disease.

***Student's Name:_____ Date:_____ _**
Print

Student's Signature: _____

Parent/Guardian: _____ Date: _____
Print

Parent/Guardian Signature: _____

***If student is under 18 years of age a signature is required by both the student and parent/guardian.**

Student Name: _____ DOB: _____

MENINGITIS FACT SHEET

What is meningococcal disease?

Meningococcal disease is a severe bacterial infection of the bloodstream or meninges (a thin lining covering the brain and spinal cord) caused by the Neisseria meningitides.

Who gets meningococcal disease? Anyone can get meningococcal disease. For some adolescents, such as first year college students living in dormitories, there is an increased risk of meningococcal disease. Every year in the United States approximately **3,000** people are infected and **300** die from the disease. Other persons at increased risk include household contacts of a person known to have had this disease, immuno-compromised people, and people traveling to parts of the world where meningococcal meningitis is prevalent.

How is the meningococcus germ spread? N. meningitides is spread by direct close contact with nose or throat discharges of an infected person. (i.e., coughing, sneezing, kissing, and sharing items such as a drinking glass, utensils or cigarettes)

What are the symptoms? High fever, headache, vomiting, stiff neck and a rash are symptoms of meningococcal disease. The symptoms may appear 2 to 10 days after exposure, but usually within 5 days. Among people who develop meningococcal disease, 10-15% die, in spite of treatment with antibiotics. Of those who live, permanent brain damage, hearing loss, kidney failure, loss of arms or legs, or chronic nervous system problems can occur.

What is the treatment for meningococcal disease? Antibiotics, such as penicillin G or ceftriaxone, can be used to treat people with
Meningococcal disease. However, **1** in **10** cases are fatal. Of those that survive, **1** in **5** suffers long-term effects that can include: brain damage, seizures, hearing loss or limb amputations.

Should people who have been in contact with a diagnosed case of meningococcal meningitis be treated? Only people who have been in close contact (household members, intimate contacts, health care personnel performing mouth-to-mouth resuscitation, day care center playmates, etc.) need to be considered for preventive treatment. Such people are usually advised to obtain a prescription for a special antibiotic (rifampin, ciprofloxacin or ceftriaxone) from their physician. Casual contact, as might occur in a regular classroom, office or factory setting, is not usually significant enough to cause concern.

Is there a vaccine to prevent meningococcal meningitis? In February 2005 the CDC recommended a new vaccine, known as Menactra™ for use to prevent meningococcal disease in people 11-55 years of age. The previously licensed version of the vaccine, Menomune™ is available for children 2-10 years old and adults older than 55 years. Both vaccines are 85% to l00% effective in preventing the 4 kinds of the 5 most common serogroups of N. meningitides (types A, C, Y, W-135). These 4 types cause about 70% of the disease in the United States. *Because the vaccines do not include type B, which accounts for about one-third of cases in adolescents, they do not prevent all cases of meningococcal disease.*

Is the vaccine safe? Are there adverse side effects to the vaccine? Both vaccines are currently available and both are safe and effective vaccines. However, both vaccines may cause mild side effects, such as redness and pain at the injection site lasting up to two days.

Who should get the meningococcal vaccine? The vaccine is recommended for all adolescents entering middle school (11-12 years old) and high school (15 years old), and all first year college students living in dormitories. However, the vaccine will benefit all teenagers and young adults in the United States. Also at increased risk are people with terminal complement deficiencies or asplenia, some laboratory workers and travelers to endemic areas of the world.

What is the duration of protection from the vaccine? Menomune™ vaccine requires a booster dose if 5 years has elapsed since receiving the vaccine and the individual is still considered at risk. The Menactra™ vaccine will probably not require booster doses, although research is still pending.

How do I get more information about meningococcal disease and vaccination? The Meningococcal vaccine is not available through Paul Smith's Health Services. Please contact your physician or your Local Public Health Department to obtain the Meningococcal vaccine. It typically costs $65-$100. Additional information about the Meningococcal vaccine is available on the websites of the New York State Department of Health, www.health.state.ny.us; the Centers for Disease Control and Prevention www.cdc.govlncidodldiseaseslindex.htin; and the American College Health Association, www.acha.org

Student Name: _____ DOB: _____

Student Health Services Check List

We strongly encourage students to sit down with a parent to go over this check list together to form a good understanding of what Student Health Services can provide and what is needed for enrollment.

- ☐ I have made or already attended an appointment with my family physician or pediatrician to fill out my paperwork.
- ☐ I have included a photo copy of my insurance card with this packet, as well as having a personal copy for my wallet or purse.
- ☐ I have discussed the concept of copays with my parents and understand what my insurance plan requires of me.
- ☐ I have signed and filled out ALL pertinent information in the health packet.

Student Health Services Packet Breakdown:

Yes ☐ No ☐ The **Demographics, Emergency Contacts, and Permission to Treat** page has been filled out and signed by the student.

Yes ☐ No ☐ The **Sharing Information** page has been filled out and signed by the student.

Yes ☐ No ☐ The **Health History** page has been filled out and reviewed with a medical provider.

Yes ☐ No ☐ The **Clinical Evaluation** page has been filled out by a medical provider.

Yes ☐ No ☐ The **Immunizations** page has been filled out by a medical provider.

Yes ☐ No ☐ The **Meningococcal Vaccination Response Form** page has been filled out and signed by the student.

A lot of physicians' offices require patients to schedule an appointment for a physical in order to fill out any paperwork. Call your family physician or pediatrician's office and schedule an appointment no later than three weeks before the start of the semester. When you go to your appointment, make sure that your doctor fills out our forms and lets you take the originals with you. That way you will have them, and not need to worry about picking them up at a later date.

Student Name: _____ DOB: _____