

**Admissions Office**  
**PO Box 265**  
**Paul Smiths, NY 12970**  
**800-421-2605 ~518-327-6016 fax**

**General Information**

Date of Entry: Fall \_\_\_\_\_ Spring \_\_\_\_\_ Area of Study: \_\_\_\_\_  
Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
E-mail: \_\_\_\_\_ Gender:  Male  Female

**Primary Emergency Contact (Parent/Guardian)**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Health Insurance Information**

Name of Insurance Carrier: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Policy/ID# \_\_\_\_\_ BIN # \_\_\_\_\_ Group# \_\_\_\_\_  
Policy Holder's Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_  
**\*PLEASE ATTACH A FRONT/BACK COPY OF YOUR HEALTH INSURANCE CARD**

**Permission to Treat**

**I, the undersigned, authorize Paul Smith's College Health Services, nursing/medical staff, to provide appropriate care for any illness or injury occurring while at PSC, to include any emergency treatment and/or mental health consult.**

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

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Consent to Share Information**

**I, the undersigned, hereby consent to the sharing of any medical information that I have provided to the Paul Smith's College Health Services as part of my enrollment/registration requirements, with the Counseling/Student Development Center, with the understanding that I may be contacted by the Counseling Center/Student Development Center and offered assistance.**

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Health History**

**This form must be completed by the student prior to doctor visit.**

**ALLERGIES:**

- No known allergies.
- Medication allergies (please list - with reaction).
- Food allergies (please list with reaction).
- Environmental allergies (Please list medications)

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**NEURO:**

- Seizures/epilepsy
- Migraine headaches
- Muscle weakness/paralysis
- History of a concussion(s)
- Vision loss
- Hearing loss
- Any other problem of the nervous system
- Family History

**None**  
Explain/Medications: \_\_\_\_\_

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**SKIN:**

- Acne
- Eczema
- Psoriasis
- Shingles/Herpes Zoster
- Skin cancer
- Any other problems of the skin
- Family History

**None**  
Explain/Medications: \_\_\_\_\_

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**ENDOCRINE:**

- Diabetes type 1
- Diabetes type 2
- Thyroid problems
- Osteoporosis or weak bones
- Obesity
- Family History

**None**  
Explain/Medications: \_\_\_\_\_

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**PSYCHIATRIC:**

- Anxiety
- Attention Deficit Disorder
- Depression
- Eating Disorder
- Suicide attempts
- Cutting yourself
- Hospitalized for psychiatric reason
- Problem with alcohol
- Problem with illegal or prescription drugs
- Obsessive-compulsive disorder
- Any other psychiatric problem
- Family History

**None**  
Explain/Medications: \_\_\_\_\_

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**BLOOD/LYMPHATIC/CANCER:**

- Anemia
- Hemophilia
- Lymphoma
- HIV/AIDS
- History of ANY type of cancer
- Sickle cell anemia
- DVT/blood clots
- Factor V Leiden, protein S, or protein C deficiency
- Von Willebrand's disease
- History of infectious mononucleosis (i.e. Mono)
- Any other problem of the blood
- Family History

**None**  
Explain/Medications: \_\_\_\_\_

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**GASTROINTESTINAL:**

- Gallbladder problems
- Hernia
- Stomach or intestinal problems
- Irritable bowel syndrome
- GERD
- Chronic abdominal pain
- Inflammatory bowel disease- Crohn's, ulcerative colitis
- Liver disease / Hepatitis
- Family History

**None**  
Explain/Medications: \_\_\_\_\_

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Student Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Health History Continued**

**RENAL:**

- Kidney Stones
  - Kidney Infections
  - History of only one kidney or horseshoe kidney
  - History of blood in the urine (even if not visible to the naked eye)
  - Protein in the urine frequently
  - Sugar in the urine frequently
  - Kidney Failure
  - Any other disorder of the kidneys, ureters, bladder, urethra
  - Family History
  - None**
- Explain/Medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**RESPIRATORY:**

- Asthma
  - Cystic fibrosis
  - Exposure to tuberculosis
  - Treatment for positive tuberculosis skin test
  - Sleep apnea
  - Any other lung problem
  - Family History
  - None**
- Explain/Medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MUSCULOSKELETAL:**

- Chronic back pain
  - Chronic neck pain
  - Broken bones requiring surgery
  - Scoliosis
  - Chronic tendonitis
  - Arthritis (Type): \_\_\_\_\_
  - Any other problem of the bones, tendons, ligaments, joints
  - Family History
  - None**
- Explain/Medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEN**

- Undescended testicle (even if you had surgery to fix it)
  - Lump or mass on the testicle
  - Any history of sexually transmitted infection
  - Hydrocele
  - Varicocele
  - Any other problem of the male reproductive system
  - Family History
  - None**
- Explain/Medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**WOMEN:**

- Breast lump or mass
  - Ovarian cyst
  - Pelvic inflammatory disease
  - Any prior sexually transmitted infections
  - Any prior abnormal Pap smear
  - Endometriosis
  - Infrequent or no menstrual cycles
  - Any other problem of the female reproductive system
  - Family History
  - None**
- Explain/Medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SURGERIES:**

- None**
- Major surgeries (Please List): \_\_\_\_\_  
\_\_\_\_\_

**MAJOR INJURIES:**

- None**
  - Major Injuries**
- Explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Student Name: \_\_\_\_\_

DOB: \_\_\_\_\_



**HEALTH REPORT/ IMMUNIZATION RECORD**

**PPD:** (Required. Must have PPD within last year)

Date PPD Given: \_\_\_\_\_

Date PPD Read: \_\_\_\_\_

PPD Results: POS/NEG \_\_\_\_\_ mm

Chest X-Ray Date: \_\_\_\_\_

Chest X-Ray Results: \_\_\_\_\_

**Measles/Mumps/Rubella(MMR):** (Required)

MMR #1: \_\_\_\_\_

MMR #2: \_\_\_\_\_

or

Measles Titer\* \_\_\_\_\_

Rubella Titer\* \_\_\_\_\_

Mumps Titer\* \_\_\_\_\_

\*attach copy of titer reports to this form

or

MD Diagnosed Disease:

Measles \_\_\_\_\_

Mumps \_\_\_\_\_

Rubella \_\_\_\_\_

**Polio:** (Recommended)

Childhood Series: # Doses \_\_\_\_\_

Date Completed: \_\_\_\_\_

**Meningitis:** (Required if resident student)

Menactra: \_\_\_\_\_ or

Menomune \_\_\_\_\_

**Tetanus/Pertussis/Diphtheria:** (Recommended)

Childhood series: # Doses \_\_\_\_\_

Date Completed: \_\_\_\_\_

TD or Tdap Booster: \_\_\_\_\_

**Varicella:** (Recommended)

Varicella #1: \_\_\_\_\_

Varicella #2: \_\_\_\_\_

MD Diagnosed Disease: \_\_\_\_\_

**Hepatitis B:** (Recommended)

Hepatitis B #1 \_\_\_\_\_

Hepatitis B #2 \_\_\_\_\_

Hepatitis B #3 \_\_\_\_\_

**Hepatitis A:** (Required if RATE or Culinary Student)

Hepatitis A #1: \_\_\_\_\_

Hepatitis A #2 \_\_\_\_\_

**HPV:** (Recommended for female students)

HPV #1: \_\_\_\_\_

HPV #2 \_\_\_\_\_

HPV #3 \_\_\_\_\_

**Clinical Evaluation**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_ Pulse: \_\_\_\_\_ Temp: \_\_\_\_\_  
Vision: Uncorrected Corrected Hearing: \_\_\_\_\_  
Right: 20/ \_\_\_\_\_ 20/ \_\_\_\_\_ Right: \_\_\_\_\_  
Left: 20/ \_\_\_\_\_ 20/ \_\_\_\_\_ Left: \_\_\_\_\_

General	Normal	Abnormal	Details
HEENT			
Heart			
Lungs & Chest			
Vascular System			
Abdomen			
Skin			
Upper Extremities			
Lower Extremities			
Spine & Musculoskeletal			
Neurologic			
Psychiatric			
Genitourinary			<input type="checkbox"/> Not done
Anorectal			<input type="checkbox"/> Not done

In your opinion, is this patient/student physically able to participate in intercollegiate athletics?  yes  no  
If not or there is limitation, please explain: \_\_\_\_\_

Have you reviewed, with the patient/student, their Health History Questionnaire for completeness and accuracy?  yes  no

Have you reviewed, with the patient/student, their Immunization Status, including Meningitis, HPV, PPD?  yes  no

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 Printed Name & address: \_\_\_\_\_  
\_\_\_\_\_

Provider's Signature: \_\_\_\_\_  
Date: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Student Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**MENINGOCOCCAL MENINGITIS 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. Return the form to Paul Smith's College, Student Health Services, PO Box 265, Paul Smiths, NY 12970.

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

Choose one and sign below.

I certify that the following student has:

- had the meningococcal meningitis immunization (Menomune™ or Menactra™) within the past 10 years.
  - Date given: \_\_\_\_\_
  - Note: If the student received the meningococcal vaccine available before February 2005 called Menomune™, please note this vaccine's protection lasts for approximately 3 - 5 years. Revaccination with the newer vaccine called Menactra™ should be considered within 3-5 years of the first vaccine.
- read, or have had explained to him/her, the information regarding meningococcal meningitis disease.
  - The student will obtain the immunization against meningococcal meningitis prior to starting college.
- read, or have had explained to him/her, the information regarding meningococcal disease.
  - The risks of not receiving the vaccine are understood.
  - The student will NOT obtain immunization against meningococcal meningitis disease.

Student's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Student's Signature: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(if student is under 18 years old, must be signed by parent/guardian)

Student's Date of Birth: \_\_\_\_\_ (mm/dd/yy) Student's ID #: \_\_\_\_\_

Student's Email Address: \_\_\_\_\_

Student's Mailing Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Student Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Meningococcal 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 meningitidis*.

**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. meningitidis* 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 100% effective in preventing the 4 kinds of the 5 most common serogroups of *N. meningitidis* (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](http://www.health.state.ny.us); the Centers for Disease Control and Prevention [www.cdc.gov/ncidod/diseases/index.htm](http://www.cdc.gov/ncidod/diseases/index.htm); and the American College Health Association, [www.acha.org](http://www.acha.org)

Revised: 04/08

Student Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Consent for Release of Information**

We at Paul Smith's College Student Health Services, request that thought and consideration be given to extending permission to allow communication between our office and the student's: parent/guardian, spouse, and or physician. This form allows for communication between parties that would otherwise not be able to discuss health concerns due to privacy policy. This form is optional and is totally revocable at any point in time by the student.

**Purpose or need for information:** This information is requested to aid in the provision of services for the below named student.

**Nature of Information to be disclosed:** All health information unless otherwise limited below:

*I hereby authorize the release of the above information to/from the person/organizations/facilities/program identified below as often as necessary to provide for care and service through the Paul Smith's College Student Health Services. I understand that the information to be released is confidential and protected from disclosure. I also understand that I have the right to revoke or limit this release at any time except to the extent that it has already been acted upon.*

*My consent to release information will expire when I am no longer receiving service from Paul Smith's College.*

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Name, Address, phone number, fax, e-mail and title of Person/organization/facility/program to which disclosure is to be made/obtained)

- Mother
  - o Name: \_\_\_\_\_ e-mail: \_\_\_\_\_
  - Address: \_\_\_\_\_
  - Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_ Fax: \_\_\_\_\_
- Father
  - o Name: \_\_\_\_\_ e-mail: \_\_\_\_\_
  - Address: \_\_\_\_\_
  - Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_ Fax: \_\_\_\_\_
- Guardian
  - o Name: \_\_\_\_\_ e-mail: \_\_\_\_\_
  - Address: \_\_\_\_\_
  - Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_ Fax: \_\_\_\_\_
- Physician
  - o Name: \_\_\_\_\_ e-mail: \_\_\_\_\_
  - Address: \_\_\_\_\_
  - Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_ Fax: \_\_\_\_\_
- Other
  - o Name: \_\_\_\_\_ e-mail: \_\_\_\_\_
  - Address: \_\_\_\_\_
  - Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Student Name: \_\_\_\_\_

DOB: \_\_\_\_\_