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’ will result in negative consequences, such as: refusal of care, 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.

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,

Abigail Fontaine, R.N. Annabelle Abbadessa

Director of Student Health Services Office Manager of Student Health Services

Afontaine@paulsmiths.edu Aabbadessa@paulsmiths.edu

Work Phone: 518-327-6349 Work Phone: 518-327-6319

Fax: 518-327-6309 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

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***

**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.

**Please print or type all information in this packet.**

**Demographics, Emergency Contacts, and Permission to Treat:**

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**](http://www.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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to student: Mother/Father/Guardian/Spouse Relationship to student: Mother/Father/Guardian/Spouse

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell 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.**

**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.**

**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.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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) Hearing:

Right: 20/\_\_\_\_\_\_\_\_ 20/\_\_\_\_\_\_\_ Right: \_\_\_\_\_\_\_\_\_\_\_ ○ Aid

Left: 20/\_\_\_\_\_\_\_\_ 20/\_\_\_\_\_\_\_ 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: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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.**

**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, MenomuneTM 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;](http://www.health.state.ny.us;) the Centers for Disease Control and Prevention [www.cdc.govlncidodldiseaseslindex.htin;](http://www.cdc.govlncidodldiseaseslindex.htin;) and the American College Health Association, [www.acha.org](http://www.acha.org)