HEALTH REPORT AND PHYSICIAN'S CERTIFICATE

Return to:
Student Health Service
State University of New York at New Paltz, 1 Hawk Drive, New Paltz, New York 12561-2443
Fax: (845)-257-3415

Student Name:_____ Date of Birth:_____ Banner # N_____

HEALTH INFORMATION FOR STUDENTS, PARENTS, AND PHYSICIANS

HEALTH REPORT AND PHYSICIAN'S CERTIFICATION OF IMMUNIZATIONS. The completed form should be mailed or faxed to the office indicated above. This form should be on file at least one month before a student's arrival to campus.

MENINGITIS VACCINATION RESPONSE FORM

New York State Public Health Law requires that all college students at New Paltz enrolled for at least six (6) semester hours must complete the following:

Check one box and sign below, after reading the information about meningococcal meningitis disease. To access this information, go to *www.newpaltz.edu/healthcenter/* and click on "Forms", then click on "Meningococcal Disease Fact Sheet."

☐ Had the Meningococcal meningitis immunization within the past 10 years.
Date received:_____ (Provide medical documentation.)

☐ 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 that I (my child) will not obtain immunization against meningococcal meningitis disease.

Signed:_____ Date:_____

To be completed and signed by parent/guardian if student is a minor

Consent for Medical Care: To the Parents/Guardians of Applicants Under 18 Years of Age Only

In order to procure any necessary medical care and to protect the clinicians and institutions involved, please sign the consent for medical treatment below. Be assured that we make every effort to notify parents at once in case of major injuries or serious illnesses.

I (print full name) _____, pursuant to the authority vested in me as the parent/guardian of (student's full name) _____ do hereby authorize the clinical staff at SUNY New Paltz's Student Health Service to provide routine medical care to my son/daughter. This care may include treatment of common illnesses, physical examinations for sports preparation, ordering of laboratory tests, prescribing of medications and the administration of immunizations to meet New York State immunization requirements. Furthermore, I do hereby authorize the clinical staff at New Paltz to seek emergency medical care from outside the clinicians if they feel it is necessary.

I understand that if my/son daughter participates in intercollegiate athletics, information about his/her medical condition and/or insurance coverage may need to be shared with the athletic training staff in order to ensure his/her safe participation in athletics. Any medical information not directly related to athletic participation will be kept confidential. My signature below includes authorization to release information to the athletic training staff as outlined above.

I understand I am free to withdraw this consent, in writing, at any time.

Signed: _____ Date: _____

TO BE COMPLETED BY STUDENTS AND PARENTS:

DEMOGRAPHICS:

Student Name: _____ Banner # N_____

Address: _____
Street City State Zip Code Country

Cell Phone: _____ Other Phone: _____

Parent or Guardian: _____ Relationship: _____

Address: _____

Cell Phone: _____ Work Phone: _____ Home Phone:_____

Primary Health Provider: _____ Years under their care: _____

Address: _____

Phone: _____ Fax: _____

Emergency Contact if Other Than Parent or Guardian:

Person: _____ Relationship: _____

Address: _____

Cell Phone: _____ Work Phone: _____ Home Phone:_____

Insurance Information:

Primary Insurance Company Name: _____

Member ID: _____ Group: _____

Insurance Company Address: _____

City: _____ State: _____ Zip Code: _____

Policy Holder: _____ Student Relationship to Insured: □ Dependent □ Self □ Spouse

HEALTH HISTORY:

Do you plan to participate in varsity athletics? □ Yes □ No

Diseases in parents and grandparents: eg. Diabetes, Hypertension, Arthritis, Cancer, Heart Disease, Depression, etc:_____

_____

Diseases in student: check box if history of this condition exists in student:

Infectious Disease	Chronic Medical Disorders	Neurologic/Psychiatric Problems
□ Chicken Pox	□ Diabetes	□ Head Injury/Concussion
□ Frequent Respiratory Infections	□ Seizure Disorder	□ Emotional Disorder
□ Mononucleosis	□ Anemia	□ Depression
□ Positive TB Skin Test	□ Sickle Cell Disease	□ Anxiety
□ Tuberculosis	□ Heart Abnormality	□ Attention Deficit Disorder
□ Malaria	□ Kidney Disease	□ Eating Disorder
□ HIV/AIDS	□ Chronic Intestinal/Stomach Problem	□ Hearing Deficit
□ Hepatitis A,B, or C	□ Arthritis	□ Visual Deficit
□ Pneumonia	□ Respiratory Allergies	□ Speech Deficits
□ Sexually Transmitted Disease	□ Hives	□ Fainting
	□ Asthma	□ Alcohol/Drug Addiction
	□ Cancer	□ Migraine Headaches
	□ Orthopedic Problems	□ Learning Disabilities

Please clarify positive responses and any medical problems not noted above: _____

_____

Severe Injuries: □ Yes □ No Explain: _____

Operations: □ Yes □ No Explain: _____

ALLERGIES: (Please Specify) □ None

Medicines: _____

Food: _____

Insect: _____

Student or Parent/Guardian Signature: _____

Student Name: _____ Date of Birth: _____

TO BE COMPLETED BY STUDENT'S PRIMARY HEALTH PROVIDER:

Provider Name: _____

Address: _____

Phone: _____ **Fax:** _____

Please list any significant past or current medical, surgical, or psychiatric conditions: ☐ **None**

_____

_____

_____

Please list any ongoing therapy, medications with dosages and directions: ☐ **None**

_____

_____

_____

Please list allergies: ☐ **None** Medicines: _____

Dietary: _____

Environmental: _____

Date of Exam: _____ **Height:** _____ **Weight:** _____ **BMI:** _____ **BP:** _____ **P:** _____

Please list all abnormal findings of your history and physical exam: _____

_____

_____

Please use check off format to acknowledge obtaining history and performing physical exam while evaluating the organ systems below.

N = Normal ABN = Abnormal NE = Not Examined

Systems: **Sex:** ☐ **male** ☐ **female**

	N	ABN	NE		N	ABN	NE		N	ABN	NE
Skin	☐	☐	☐	Lymphatics	☐	☐	☐	Female: Breasts	☐	☐	☐
HEENT	☐	☐	☐	Abdominal Organs	☐	☐	☐	Pelvic	☐	☐	☐
Lungs	☐	☐	☐	Ano Rectal Area if indicated	☐	☐	☐	(if indicated)			
Heart	☐	☐	☐	Orthopedic: Limbs	☐	☐	☐	Male: Testes	☐	☐	☐
Blood vessels	☐	☐	☐	Spine	☐	☐	☐	Inguinal Canals	☐	☐	☐
				Endocrine	☐	☐	☐	Neurologic	☐	☐	☐

Lab:

Urinalysis:	N	ABN	Sediment if indicated
Glucose	☐	☐	
Protein	☐	☐	
Blood	☐	☐	

Information required for Varsity Athletes:

Sickle Cell Trait: ☐ Present ☐ Absent ☐ Unknown

Do you recommend further evaluation? ☐ Yes ☐ No _____

Will you remain involved in this student's care? ☐ Yes ☐ No

Is this student able to participate in all physical activities including intercollegiate athletics? ☐ Yes ☐ No

Is this student able to meet the physical and emotional demands of college? ☐ Yes ☐ No

Provider Signature: _____

Student Name: _____ Date of Birth: _____

To be completed by student's primary health provider or provide copies of physician documented immunization records.

REQUIRED IMMUNIZATIONS:

MMR (Measles, Mumps, Rubella) List two dates of vaccination:

1._____ 2._____

Two doses* (The 1st dose administered after the student's first birthday and the 2nd dose administered at least 1 month after the 1st dose)

OR

Measles 1._____ 2._____ **Mumps**_____ **Rubella** _____

Two doses* (as above) One dose after 1st birthday One dose after 1st birthday

OR

Date and result of blood test – demonstration of immunity

To **Measles** _____ **Mumps** _____ **Rubella** _____

RECOMMENDED VACCINES:

Meningitis Menactra _____ Menomune_____ Menveo _____

M/D/Y M/D/Y M/D/Y

If student refuses the meningitis vaccine direct them to the Meningitis Vaccination Response Form on the front of their Health Report packet

Hepatitis B 3 doses _____ _____ _____

M/D/Y M/D/Y M/D/Y

Hepatits A 2 doses _____ _____

M/D/Y M/D/Y

Varicella 2 doses _____ _____ ☐ Had Varicella Disease _____

M/D/Y M/D/Y M/Y

Polio 3 doses minimum to complete series ☐ Incomplete ☐ Completed _____

M/D/Y

Tetanus/Diphtheria within 10 years prior to registration Td _____ **or** Tdap _____

M/D/Y M/D/Y

HPV Vaccine 3 doses _____ _____ _____

M/D/Y M/D/Y M/D/Y

TST (Tuberculin Skin Test)

(**Within 6 months if indicated**, please refer to the Tuberculosis Screening sheet on page 5 of this form for indications)

- ***TST is required for students from: CHINA, INDIA, JAPAN, MEXICO, TURKEY, and other countries listed on the Tuberculosis Screening Sheet.***

☐ **TST test given:** Placed: _____ Read:_____ **Result:** _____

M/D/Y M/D/Y (Record actual mm of induration, transverse diameter, if no induration, write "0")

☐ **Chest x-ray** (required if tuberculin skin test is positive) **Result:** ☐ Normal ☐ Abnormal

PLEASE INCLUDE COPY OF WRITTEN CHEST X-RAY REPORT

Provider Name: _____ **Signature:** _____

Student Name: _____ Date of Birth: _____

Tuberculosis Screening

TST (Tuberculin Skin Test) *is required for international students from countries listed below*

HIGH RISK COUNTRIES:

Afghanistan, Algeria, Angola, Argentina, Armenia, Azerbaijan, Bangladesh, Belarus, Belize, Benin, Bhutan, Bolivia, Bosnia and Herzegovina, Botswana, Brazil, Brunei Darussalam, Bulgaria, Burkina Faso, Burundi, Cambodia, Cameroon, Cape Verde, Central African Republic, Chad, China, Colombia, Comoros, Congo, Cote d'Ivoire, Democratic People's Republic of Korea, Democratic Republic of the Congo, Djibouti, Dominican Republic, Ecuador, El Salvador, Equatorial Guinea, Eritrea, Estonia, Ethiopia, Fiji, Gabon, Gambia, Georgia, Ghana, Guatemala, Guinea, Guinea-Bissau, Guyana, Haiti, Honduras, India, Indonesia, Iran, Iraq, Japan, Kazakhstan, Kenya, Kiribati, Kuwait, Kyrgyzstan, Lao People's Democratic Republic, Latvia, Lesotho, Liberia, Libya, Lithuania, Madagascar, Malawi, Malaysia, Maldives, Mali, Marshall Islands, Mauritania, Mauritius, Mexico, Micronesia, Mongolia, Morocco, Mozambique, Myanmar, Namibia, Nauru, Nepal, Nicaragua, Niger, Nigeria, Niue, Pakistan, Palau, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Poland, Portugal, Qatar, Republic of Korea, Republic of Moldova, Romania, Rwanda, Saint Vincent and the Grenadines, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, Singapore, Solomon Islands, Somalia, South Africa, South Sudan, Sri Lanka, Sudan, Suriname, Swaziland, Tajikistan, Thailand, The former Yugoslav Republic of Macedonia, Timor-Leste, Togo, Trinidad and Tobago, Tunisia, Turkey, Turkmenistan, Tuvalu, Uganda, Ukraine, United Republic of Tanzania, Uruguay, Uzbekistan, Vanuatu, Venezuela, Viet Nam, Yemen, Zambia, Zimbabwe

Is this student from one of these high risk countries? **□ Yes □ No**
Yes response requires a TST to be done.
Please record results on page 4 of Health Report.

Does student have signs or symptoms of active disease? **□ Yes □ No**
(Unexplained cough greater than 2 weeks duration, unexplained fevers, chills, night sweats, weight loss, or swollen glands) **Yes response requires a TST to be done.**

TST are required of students at risk for Tuberculosis exposure:

1. Students who have arrived within the past five years from countries where TB is endemic as listed above.
2. Recent close contact with someone with infectious TB disease.
3. Travel* to/in a high-prevalence area (countries noted above)
4. Fibrotic changes on a prior chest x-ray suggesting inactive or past TB disease
5. HIV/AIDS
6. Organ transplant recipient
7. Immunosuppressed (equivalent of > 15 mg/day of prednisone for > 1 month or TNF-α antagonist)
8. History of illicit drug use
9. Resident, employee, or volunteer in a high-risk congregate setting (e.g., correctional facilities, nursing homes, Homeless shelters, hospitals, and other health care facilities)
10. Medical condition associated with increased risk of progressing to TB disease if infected [e.g., diabetes mellitus, silicosis, head, neck, or lung cancer, hematologic or reticuloendothelial disease such as Hodgkin's disease or leukemia, end stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (i.e., 10% or more below ideal for the given population)]

* *The significance of the travel exposure should be discussed with a health care provider and evaluated.*

Is student a member of high risk group as defined above? **□ Yes □ No**
Yes response requires a TST to be done.

A history of BCG vaccination should not preclude testing of a member of a high-risk group

Provider Signature: _____ Date: _____

WELCOME

to

State University of New York at New Paltz

ATTENTION STUDENTS

All 5 pages of this form should be completed.
(Pages 1-2 by you, and pages 3-5 by your physician)

This will provide us the necessary information to take good care of you and conform to the NYS Public Health Law, allowing you to maintain your academic registration.

New Paltz
STATE UNIVERSITY OF NEW YORK
Student Health Service ▪ Division of Student Affairs