New Paltz
STATE UNIVERSITY OF NEW YORK
Student Health Services

Fall 2012-Spring 2013

ATTENTION STUDENTS AND PARENTS

Please be advised that the Health Report and Physician's Certification of immunization records needs to be completed and mailed or faxed to the Student Health Service at least 30 days prior to the beginning of the semester.

Basic to good student health care is the Student Health Service's knowledge of the health status of each student. This Health Report and Physician's Certificate Form is the foundation of each student's medical record at the college, and thus a critical element in that knowledge.

The Student Health Service serves currently registered students when the college is in session.

We appreciate your attention to this important time-sensitive matter, and anticipate receiving these documents by the date requested.

Sincerely,

Richard J. Ordway Jr. M.D.
Director

1 Hawk Drive ▪ New Paltz, NY 12561-2443 ▪ (845) 257-3400 ▪ Fax (845) 257-3415 ▪ www.newpaltz.edu /healthcenter

HEALTH REPORT AND PHYSICIAN'S CERTIFICATE

Return to:

Student Health Services

SUNY New Paltz, 1 Hawk Drive, New Paltz, New York 12561-2443

Fax: (845)-257-3415

Student Name: ____________________________________ Date of Birth: _______________________________

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 INFORMATION RESPONSE FORM

New York State Public Health Law requires that all university students enrolled for at least six (6) semester hours or the Equivalent per semester complete the following:

Check one box and sign below, after reading "Information About Meningococcal Meningitis." To access this information, go to *www.newpaltz.edu/healthcenter/* and click on "Forms", then click on "Meningococcal Disease/Vaccine Acknowledgement Form."

☐ 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

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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 of the State University of New York College 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: ______________________________ ID # ____________ Date of Birth: ______________________

Address: ____

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:

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:

<u>Infectious Disease</u>

- ☐ Chicken Pox
- ☐ Frequent Respiratory Infections
- ☐ Mononucleosis
- ☐ Positive TB Skin Test
- ☐ Tuberculosis
- ☐ Malaria
- ☐ HIV/AIDS
- ☐ Hepatitis A,B, or C
- ☐ Pneumonia
- ☐ Sexually Transmitted Disease

<u>Chronic Medical Disorders</u>

- ☐ Diabetes
- ☐ Seizure Disorder
- ☐ Anemia
- ☐ Sickle Cell Disease
- ☐ Heart Abnormality
- ☐ Kidney Disease
- ☐ Chronic Intestinal/Stomach Problem
- ☐ Arthritis
- ☐ Respiratory Allergies
- ☐ Hives
- ☐ Asthma
- ☐ Cancer
- ☐ Orthopedic Problems

<u>Neurologic/Psychiatric Problems</u>

- ☐ Head Injury/Concussion
- ☐ Emotional Disorder
- ☐ Depression
- ☐ Anxiety
- ☐ Attention Deficit Disorder
- ☐ Eating Disorder
- ☐ Hearing Deficit
- ☐ Visual Deficit
- ☐ Speech Deficits
- ☐ Fainting
- ☐ Alcohol/Drug Addiction

Medical problems other than those above and please clarify any positive responses:

____

____

Severe Injuries: ☐ Yes ☐ No Explain: ____

Operations: ☐ Yes ☐ No Explain: ____

Allergies (Please Specify)

Medicines: ____

Food: ____

Insect: ____

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:** ________ **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
Skin	☐	☐	☐
HEENT	☐	☐	☐
Lungs	☐	☐	☐
Heart	☐	☐	☐
Blood vessels	☐	☐	☐

	N	ABN	NE
Lymphatics	☐	☐	☐
Abdominal Organs	☐	☐	☐
Ano Rectal Area if indicated	☐	☐	☐
Orthopedic: Limbs	☐	☐	☐
Spine	☐	☐	☐
Endocrine	☐	☐	☐

	N	ABN	NE
Female: Breasts	☐	☐	☐
Pelvic (if indicated)	☐	☐	☐
Male: Testes	☐	☐	☐
Inguinal Canals	☐	☐	☐
Neurologic	☐	☐	☐

Lab:

Urinalysis:	N	ABN
Glucose	☐	☐
Protein	☐	☐
Blood	☐	☐

Sediment if indicated

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: ______________________________

MV 2011

Student Name: ______________________________ Date of Birth: ____________________

To be filled out 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 __________
M/D/Y M/D/Y

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

Tetanus/Diphtheria within 10 years prior to registration Td __________ **or** Tdap __________
M/D/Y M/D/Y

Polio 3 doses minimum to complete series ☐ Complete ☐ Incomplete

Hepatitis B 3 doses __________ __________ __________
M/D/Y M/D/Y M/D/Y

Varicella 2 doses __________ __________
M/D/Y M/D/Y

HPV Vaccine 3 doses __________ __________ __________
M/D/Y M/D/Y M/D/Y

Hepatits A 2 doses __________ __________
M/D/Y M/D/Y

PPD (within 6 months if indicated, please refer to the Tuberculosis Screening sheet included with this form for indications)

Date Given: __________ Date Read:__________
M/D/Y M/D/Y

Result: __________ (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 submit copy of written chest x-ray report to Student Health Service.

Provider Name:__________________________ **Signature:** __________________________

New Paltz
STATE UNIVERSITY OF NEW YORK

Tuberculosis Screening

Student Name: ____ Date of Birth: ___________________________

1. 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)
   If no, proceed to #2.

2. Is student a member of high risk group as defined below? ☐ Yes ☐ No
   If no (to questions 1 and 2), stop. If yes (to questions 1 and 2), place tuberculin skin test (Mantoux only: Inject 0.1 ml of purified protein derivative (PPD) tuberculin containing five tuberculin units (TU) intradermally into the volar (inner) surface of the forearm.) A history of BCG vaccination should not preclude testing of a member of a high-risk group.

Categories of High Risk Students:

1. Students who have arrived within the past five years from countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Therefore, students should undergo TB screening if they have arrived from countries EXCEPT those on the following list:

   Albania, America Samoa, Andorra, Antigua and Barbuda, Australia, Barbados, Belgium, Bermuda, British Virgin Islands, Canada, Cayman Islands, Chile, Cook Islands, Costa Rica, Cuba, Cyprus, Czech Republic, Denmark, Dominica, Finland, France, Germany, Greece, Grenada, Hungary, Iceland, Ireland, Israel, Italy, Jamaica, Jordan, Lebanon, Libyan Arab Jamahiriya, Luxembourg, Malta, Monaco, Montserrat, Netherlands, Netherlands Antilles, New Zealand, Norway, Puerto Rico, Saint Kitts and Nevis, St. Lucia, Samoa, San Marino, Slovakia, Slovenia, Sweden, Switzerland, Trinidad and Tobago, Turks and Caicos Islands, United Arab Emirates, United Kingdom, United States Virgin Islands, United States of America

Other Categories of High Risk Students include:

2. Recent close contact with someone with infectious TB disease.
3. Travel* to/in a high-prevalence area (countries other than the low TB prevalence 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.*