New Paltz
STATE UNIVERSITY OF NEW YORK
Student Health Service ▪ Division of Student Affairs
1 Hawk Drive ▪ New Paltz, NY 12561-2443 ▪ 845-257-3400 ▪ Fax 845-257-3415
healthservice@newpaltz.edu

Health Report

Student Name: _____ Student ID # | N | | | | | | | | |

Date of Birth: _____

Student Health Service

Welcomes

New Students

Student's Health Information

Completed form should be mailed, faxed or emailed to Student Health Service. Health Information should be on file at least one month before student's arrival to campus.

Attention Students

Student and their parents should complete pages 1-4.

Pages 5 should be completed by your **primary health care provider**. Page 6 should be completed if you haven't already submitted your **Immunization Records** or if you responded **YES** to any questions on page 4 indicating a Tuberculosis Test is needed.

Completed form will provide us the background information necessary to take good care of you and ensure compliance with NYS Public Health Law.

*If you have been vaccinated for COVID-19 or tested positive, please include those dates below. Be sure to log on to my.newpaltz.edu then click on 'View your COVID-19 Profile' and be sure to upload this information to your profile.

COVID-19 Information	**Disease** + PCR Test	**Vaccinations**		
		Pfizer	Moderna	Janssen
Date: M/D/Y				
Date: M/D/Y				

MENINGITIS VACCINATION RESPONSE FORM

New York State Public Health Law requires all college students enrolled for at least six credits per semester complete the following:

Student Name _____
Last First

Check one box and sign below.

☐ I had a **Meningococcal ACWY immunization within the past 5 years.** Medical documentation required.

[Note: The Advisory Committee on Immunization Practices recommends that all first-year college students up to age 21 years should have at least 1 dose of Meningococcal ACWY vaccine not more than 5 years before enrollment. Young adults aged 16 through 23 years may choose to receive the Meningococcal B vaccine series. College students should discuss the Meningococcal B vaccine with a healthcare provider.]

☐ I read, or have had explained to me, the information regarding meningococcal disease. *To access this information, go to:* www.newpaltz.edu/healthcenter/forms.html and click on the Meningococcal Disease Fact Sheet. I understand the risks of not receiving the vaccine. I have **decided, I (my child) will not obtain immunization against Meningococcal ACWY disease.**

Signed _____ Date _____

Parent/guardian to complete and sign if student is a MINOR

CONSENT FOR MEDICAL CARE: To the Parents/Guardians of Applicants Under 18 Years of Age

In order to procure any necessary medical care for your student and to protect the clinicians and institutions involved, please sign the consent for medical treatment below. We make every effort to notify parents/guardians in case of major injuries or serious illnesses.

I (print your 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 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:_____ Dated:_____

TO BE COMPLETED BY STUDENTS AND PARENTS:

DEMOGRAPHICS:

Student Name: _____

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 (Does not apply to International Students):

PLEASE INCLUDE A PHOTOCOPY OF FRONT AND BACK OF STUDENT'S HEALTH INSURANCE CARD

Primary Insurance Company Name: _____

Member ID: _____ Policy Holder's Name: _____

Student Relationship to Insured: ☐ Dependent ☐ Self ☐ Spouse

HEALTH HISTORY:

Are you on a Varsity Athletics Roster? ☐ No ☐ Yes **If yes, which sport?** _____

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:

Chronic Medical Disorders
- ☐ Diabetes
- ☐ Seizure Disorder
- ☐ Anemia
- ☐ Sickle Cell Disease
- ☐ Heart Abnormality
- ☐ Kidney Disease
- ☐ Chronic Intestinal/Stomach Problem
- ☐ Arthritis
- ☐ Respiratory Allergies
- ☐ Hives
- ☐ Cancer
- ☐ Orthopedic Problems
- ☐ Asthma: **If yes, answer the following:**

Neurologic/Psychiatric Problems
- ☐ Head Injury/Concussion
- ☐ Emotional Disorder
- ☐ Depression
- ☐ Anxiety
- ☐ Attention Deficit Disorder
- ☐ Eating Disorder
- ☐ Hearing Deficit
- ☐ Visual Deficit
- ☐ Speech Deficits
- ☐ Fainting
- ☐ Alcohol/Drug Addiction
- ☐ Migraine Headaches
- ☐ Learning Disabilities

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

Triggers: ☐ Weather Changes ☐ Colds ☐ Exercise ☐ Allergies ☐ Other: _____

Medication for Asthma (e.g. Inhaler, nebulizer): _____

Please list any MEDICAL PROBLEMS not noted above. Please clarify any positive responses. _____

_____

Severe Injuries: ☐ No ☐ Yes Explain: _____

Operations: ☐ No ☐ Yes Explain: _____

CURRENT MEDICATIONS: _____

ALLERGIES to Medication: ☐ No ☐ Yes _____

ALLERGIES to Food: ☐ No ☐ Yes _____ ☐ Mild ☐ Moderate ☐ Severe

ALLERGIES to Insects: ☐ No ☐ Yes _____ ☐ Mild ☐ Moderate ☐ Severe

If your reaction is ***moderate or severe***, what treatment do you take when you are exposed to the allergen? _____

Do you require an EpiPen? ☐ Yes ☐ No

Student or Parent/Guardian Signature: _____

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heathservice@newpaltz.edu

Date: _____

Name:_____ Student ID # _____ Cellphone # _____

TUBERCULOSIS TEST IS REQUIRED FOR INTERNATIONAL STUDENTS FROM THE COUNTRIES LISTED BELOW.

Tuberculosis (TB) is still a worldwide health problem. Screening for TB means assessing each student's risk for developing active TB while studying at New Paltz. Testing is required for students whose screening indicates an increased risk. Students with a TST or a blood test that indicates exposure to TB are required to have a chest x-ray to be TB compliant at New Paltz.

High Risk Countries:

Angola, Azerbaijan, Bangladesh, Belarus, Botswana, Brazil, Cambodia, Cameroon, Central African Republic, Chad, China, Congo, Democratic People's Republic of Korea, Democratic Republic of the Congo, Eswatini (formerly Swaziland), Ethiopia, Ghana, Guinea-Bissau, India, Indonesia, Kazakhstan, Kenya, Kyrgyzstan, Lesotho, Liberia, Malawi, Mozambique, Myanmar, Namibia, Nigeria, Pakistan, Papua New Guinea, Peru, Philippines, Republic of Moldova, Russia, Sierra Leone, Somalia, South Africa, Tajikistan, Thailand, Uganda, Ukraine, United Republic of Tanzania, Uzbekistan, Vietnam, Zambia, Zimbabwe

(Based on 2020 WHO statistics)

Are you a student from one of the high risk countries listed above?	☐ Y ☐ N	If yes, circle birth country
Do you have signs or symptoms of active TB? (Unexplained cough greater than 2 weeks duration, fevers, chills, night sweats, weight loss or swollen glands)	☐ Y ☐ N	
Tuberculosis Screening Questions:		
Have you ever had contact with persons known or suspected to have active TB?	☐ Y ☐ N	If yes, when? _____
Have you stayed in a country listed above for longer than 2 weeks?	☐ Y ☐ N	If yes, when? _____ How long did you stay? _____ Which country? _____
Have you ever been a resident, employee or volunteer in a correctional facility, nursing home, homeless shelter or other health care facility within the last five years?	☐ Y ☐ N	If yes when? _____ If yes what facility? _____
Any yes response to questions above requires a TST or blood work to be done		

Students with a history of a positive Tuberculosis Test		
Have you previously had a positive TST that indicate TB exposure?	☐ Y ☐ N	**Yes answer requires a blood test or chest x-ray**
Have you previously had a blood test that indicate TB exposure?	☐ Y ☐ N	**Yes answer requires a chest x-ray**

Student Name: _____ Date of Birth: _____
M / D / Y

TO BE COMPLETED BY STUDENT'S PRIMARY HEALTH PROVIDER:

STAMP:

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**

_____

_____

ALLERGIES: (PLEASE SPECIFY)

Allergies to Medication: _____

Allergies to Food: _____

Allergies to Insects: _____

No Allergies ☐

Epipen prescribed? ☐ Yes ☐ No

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

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

_____

_____

Please use check off format below to document history and physical:

N = Normal ABN = Abnormal NE = Not Examined

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

Urinalysis:	N	ABN
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: _____

To be completed by student's health care provider or attach a copy of provider's immunization records.

Student Name: _____ **Date of Birth**: _____

REQUIRED IMMUNIZATIONS:

Vaccine	Date: M/D/Y	Date: M/D/Y
MMR (Measles, Mumps, Rubella) Two doses required (1st dose after student's first birthday, 2nd dose at least 28 days after the 1st)		
OR		
Measles Two doses required as above		
Mumps One dose after 1st birthday		
Rubella One dose after 1st birthday		
OR		
Blood Titers (Please include documentation)		
Measles		
Mumps		
Rubella		

Tuberculosis Test:

If indicated, it must be within 6 months. Please refer to the Tuberculosis Screening Form page 4 of Health Report for indications.

- **TST (Tuberculin Skin Test) or QFTG (QuantiFERON TB Gold) is required for students from China, India, Brazil, and other high risk countries listed on page 4**

☐ **Student is at low risk for TB exposure: Tuberculosis test not done**

☐ **TST test done:** Date Placed: _____ (M/D/Y) Date Read: _____ (M/D/Y)

Result:_____ (Record actual mm of induration, transverse diameter, if no induration, write "0")

☐ **QFTG done**: Date done: _____ (M/D/Y) Result: _____ (please include copy of lab report)

Chest x-ray (required if TST or QFTG is positive) **Result:** ☐ Normal ☐ Abnormal

PLEASE SUBMIT COPY OF WRITTEN CHEST X-RAY REPORT TO STUDENT HEALTH SERVICE

RECOMMENDED VACCINES:

Vaccine	Date M/D/Y	Date M/D/Y	Date M/D/Y
Meningitis (ACWY) Menactra / Menveo / MenQuadfi			
Meningitis B Bexsero / Trumenba 2 or 3 doses			
Hepatitis B 3 doses			
Hepatitis A 2 doses			
Varicella 2 doses			☐ Disease
Last Booster Td			
Last Booster Tdap			
Human Papilloma Virus Gardasil 4 / 9			
Polio 3 doses minimum to complete series	☐ Completed Date: _____		☐ Incomplete

Provider Name: _____ **Signature:** _____