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.
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: __________________

□ 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: ____________________________________________________________
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

<table>
<thead>
<tr>
<th>Systems:</th>
<th>N</th>
<th>ABN</th>
<th>NE</th>
<th>Sex:</th>
<th>□ male</th>
<th>□ female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin</td>
<td></td>
<td></td>
<td></td>
<td>Female: Breasts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymphatics</td>
<td></td>
<td></td>
<td></td>
<td>Pelvic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdominal Organs</td>
<td></td>
<td></td>
<td></td>
<td>(if indicated)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs</td>
<td></td>
<td></td>
<td></td>
<td>Male: Testes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymphatics</td>
<td></td>
<td></td>
<td></td>
<td>Inguinal Canals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthopedic: Limbs</td>
<td></td>
<td></td>
<td></td>
<td>Neurologic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endocrine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Lab:

<table>
<thead>
<tr>
<th>Urinalysis:</th>
<th>N</th>
<th>ABN</th>
<th>Sediment if indicated</th>
<th>Information required for Varsity Athletes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glucose</td>
<td></td>
<td></td>
<td></td>
<td>Sickle Cell Trait: □ Present □ Absent □ Unknown</td>
</tr>
<tr>
<td>Protein</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 primary health provider or provide copies of physician documented immunization records.

REQUIRED IMMUNIZATIONS:

MMR (Measles, Mumps, Rubella): list dates of vaccination:

1. ____________   2. ____________
M/D/Y               M/D/Y
Two doses* (The 1st dose administered after the student’s first birthday and the 2nd dose administered at least 28 days after the 1st)

OR if given as separate vaccinations:

Measles  1. ____________   2. ____________  Mumps ____________  Rubella ____________
M/D/Y      M/D/Y            M/D/Y                  M/D/Y
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 ________________
Date and result Date and result Date and result

RECOMMENDED VACCINES:

Menactra ____________  Menomune ____________  Menevo ____________
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

Hepatitis A  2 doses
M/D/Y      M/D/Y

Varicella  2 doses
M/D/Y      M/D/Y
□ Had Varicella Disease ____________
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: _______________________________
Tuberculosis Screening

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

HIGH RISK COUNTRIES:

Afghanistan, Algeria, Angola, 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
(Explain 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: ______________