

PERSONAL HISTORY:

Give details for each "yes" (including date of occurrence) on bottom of this page or attach a separate sheet if needed. Do you have or have you ever had:

	Yes	No		Yes	No		Yes	No		Yes	No
Anemia			Infectious mononucleosis			Joint disease/injury			Insomnia		
Diabetes			Chicken pox			Back problem/scoliosis			Anorexia/bulimia		
Thyroid problem			Ear/nose/throat problem			Skin disorders			Operations:		
Sinusitis			Visual problem			Tumor/cancer			appendectomy		
Bronchitis/pneumonia			Hearing loss			Seizure disorder			tonsillectomy		
Asthma			Recurrent headaches			Jaundice/hepatitis			hernia		
Hay fever			Head injury/concussion			Kidney disease			Overnight hospital		
Allergies:			Heart problem			Bladder infections			Other chronic illness		
drugs			High blood pressure			Stomach problems			Absent periods		
food			Faintness with exertion			Intestinal problems			Severe cramps		
bees			Chest pain with exertion			Psychiatric disorders					
other			High cholesterol			Depression/anxiety					

Has your physical activity been restricted due to illness, athletic or other injury in the last five years? Explain.

Have you received treatment or counseling for an emotional or psychiatric problem or eating disorder? If yes, please list diagnoses, dates, treatment, and status. If ongoing treatment is required, please provide current providers.

What medication do you take on a regular basis? List name(s)/dose(s) and prescriber. (including over-the-counter, herbal or supplements)

If you anticipate requiring accommodation on the basis of a chronic medical condition, psychological diagnosis, ADHD or a learning disability, please contact the Office for Accessibility and Educational Opportunity at 845-437-7584 to discuss your needs. (See also Self-Identification Form located in matriculation packet.)

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES OR NO. IF YES, PLEASE LIST:

Do you: smoke? No Yes How much and for how long? _____
 drink alcohol? No Yes How much and for how long? _____
 use drugs? No Yes How much and for how long? _____

Have you ever received treatment for any of the above?

I affirm the above is complete and accurate.

STUDENT'S SIGNATURE

Date

Please use this space to explain any answers to personal history questions.

MEDICAL AUTHORIZATION AND CONSENT FORM

Must be completed by all students.

FOR STUDENT

I agree to allow St. Francis Hospital/Vassar Brothers Medical Center to provide Vassar College Health Service with information concerning any medical treatments I may require during the Vassar College academic year. I understand that this medical information is necessary for appropriate follow up care by Vassar College Health Service or private physicians to whom I may be referred.

Student signature

Print name

Date

FOR PARENTS

PARENTAL CONSENT:

Student name _____

Students under 18 years of age must have a parent or guardian sign below.

Parental consent is required for students under 18 years of age for the purpose of initiating diagnosis and treatment in the event of an emergency.

I _____ hereby authorize and appoint Vassar College Health Service staff and/or local hospital medical staff to act in my absence for the purpose of consenting to necessary emergency medical treatment.

I agree to allow St. Francis Hospital/Vassar Brothers Medical Center to provide Vassar College Health Service with information concerning any medical treatments the above may require during the Vassar College academic year. I understand that this medical information is necessary for appropriate follow up care by Vassar College Health Service or private physicians to whom I may be referred.

Parent/Guardian signature

Print Parent/Guardian name

Date

Please note: **SIGNATURE REQUIRED** by student or parent/guardian

MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE FORM

New York State Public Health Law requires that all college students complete the following form. Please see enclosed Meningococcal Disease Information sheet for your review.

Check one box and sign below.

I have (for students under the age of 18: My child has):

- had the meningococcal meningitis immunization within the past 10 years.

Date received: _____ Menomune
 Menactra

[Note: If you (your child) received the meningococcal vaccine before February 2005 called Menomune™, please note this vaccine's protection lasts for approximately 3 to 5 years. Revaccination with the new conjugate vaccine called Menactra™ should be considered within 3-5 years after receiving Menomune™.]

- read, or have had explained to me, the information regarding meningococcal meningitis disease. I (my child) will obtain immunization against meningococcal meningitis within 30 days and submit documentation to the Vassar College Health Service.
- 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.

SIGNATURE OF STUDENT _____ Date _____
(or Parent / Guardian if student is a minor)

For availability of the meningitis vaccine in your local area, please contact your family doctor or local health department.

The Menactra vaccine is offered at the Vassar College Health Service at a cost of \$115.

We encourage you to carefully review the enclosed fact sheet. Additional information is also available on the websites of the NYS Dept. of Health, www.nyhealth.gov.

MEDICAL FORM PART II — to be completed and signed by a Healthcare Provider

All entering students must have a physical examination and immunization history completed and signed by a Healthcare Provider

PHYSICAL EXAM (must be within one year of admission)

Name _____
Last First Middle Gender

Ht. _____ inches Wt. _____ lbs. Underweight Overweight

BP: _____/_____ Pulse _____/min.

Visual Acuity OD: _____ near _____ far Corrected: OD: _____ near _____ far
OS: _____ near _____ far Corrected: OS: _____ near _____ far

Hearing Screen (25 dB) AD AS

Head: Normal Abnormal (describe) _____
Eyes: Normal Abnormal (describe) _____
Ears: Normal Abnormal (describe) _____
Nose: Normal Abnormal (describe) _____
Throat: Normal Abnormal (describe) _____
Neck: Normal Abnormal (describe) _____
Chest: Normal Abnormal (describe) _____
Lungs: Normal Abnormal (describe) _____
Heart: Normal Abnormal (describe) _____
Abdomen: Normal Abnormal (describe) _____
Genitalia: Normal Abnormal (describe) _____
Skin: Normal Abnormal (describe) _____
Musculoskeletal: Normal Abnormal (describe) _____
Neurological: Normal Abnormal (describe) _____

REQUIRED: Within the past 12 months: Tuberculosis Screening / Mantoux Test OR QuantiFeron-TB Gold blood test.
(QuantiFeron-TB Gold blood test is the recommended method for students who have received BCG)

RESULT: NEG _____ **POS** _____ mm induration _____ **Date Given:** _____ **Date Read:** _____
Month Day Year Month Day Year
OR QuantiFeron Gold – Results / Date _____ (must be read within 48-72 hrs)

Any positive reactors to TB screening — must provide written documentation by clinician.

If positive – Chest x-ray report and date _____

Had INH Treatment _____
Month Day Year

LAB (optional): Urinalysis: _____ SMAC: _____
CBC: _____ Other: _____

Please describe any significant illnesses, injuries, or hospitalizations in this patient's past history.

Please comment on any physical or emotional problems that the Health Service should be aware of regarding this patient, including past history, medications and current treatments.

HEALTHCARE PROVIDER

Signature: _____ Address: _____

Name of physician: _____ Telephone: _____

Date: _____ Fax: _____

IMMUNIZATION HISTORY — to be completed and signed by a Healthcare Provider

Name: _____ DOB: _____ DATE: _____

A. M.M.R. (Measles, Mumps, Rubella)

2 doses **required** by New York State Public Health Law – must be at least 28 days apart

- 1. Dose 1 given at age 12-15 months or later ... _____
Month Day Year
- 2. Dose 2 given at least 28 days after 1st dose and after age 15 months..... _____
Month Day Year

If MMR given separately:

MEASLES (Rubeola) (check appropriate box)

- 1. Two doses of vaccine – the 1st dose after first birthday and the 2nd dose at least 28 days after the 1st dose but after 15 months of age. Dose 1 _____ Dose 2 _____
Month Day Year Month Day Year
- or 2. Had disease- confirmed by office record _____
Month Day Year
- or 3. Immunity demonstrated by titer _____
Month Day Year

MUMPS (check appropriate box)

- 1. One dose of vaccine after first birthday _____
Month Day Year
- or 2. Had disease- confirmed by office record _____
Month Day Year
- or 3. Immunity demonstrated by titer _____
Month Day Year

RUBELLA (check appropriate box)

- 1. One dose of vaccine after first birthday _____
Month Day Year
- or 2. Immunity demonstrated by titer _____
Month Day Year

B. MENINGOCOCCAL VACCINE (highly recommended)

Meningococcal conjugate (preferred, data for revaccination pending) _____
Month Day Year

Meningococcal polysaccharide (acceptable alternative if conjugate not available:
reactivate every 3-5 yrs if increased risk continues)... _____
Month Day Year

C. TETANUS-DIPHTHERIA-PERTUSSIS

Primary series with DTaP, DTP,DT, or Td and booster with Td or Tdap in the last 10 years.

- 1. Primary series of four doses with DTaP, DTP, DT, or Td:
completed series of immunizations _____
Month Day Year
- 2. Tetanus-Diphtheria-acellular Pertussis Tdap _____
Month Day Year
- and/or
- 3. Tetanus-Diphtheria (Td) booster with the last ten years _____
Month Day Year

D. POLIO

Completed primary series of polio immunization yes no

Type of vaccine Oral (3 doses required) Inactivated (4 doses required)

Date completed _____
Month Day Year

E. VARICELLA (chicken pox)

History of disease yes no

Immunization if given: Dose # 1 _____ Dose # 2 _____
Month Day Year Month Day Year

F. HEPATITIS B (strongly advised)

Immunization (Hepatitis B)

#1 _____ #2 _____ #3 _____
Month Day Year Month Day Year Month Day Year

or

Immunization (Combined Hepatitis A and Hepatitis B)

Completed series of immunizations _____
Month Day Year

G. HEPATITIS A (if given)

Immunization (Hepatitis A)

#1 _____ #2 _____
Month Day Year Month Day Year

or

Immunization (Combined Hepatitis A and Hepatitis B)

Completed series of immunizations _____
Month Day Year

H. QUADRIVALENT HUMAN PAPILOMAVIRUS VACCINE (HPV) (if given)

Dose # 1 _____ Dose # 2 _____ Dose # 3 _____
Month Day Year Month Day Year Month Day Year

I. OTHER _____

J. TUBERCULOSIS SCREENING — REQUIRED WITHIN THE PAST 1 YEAR - PLEASE DOCUMENT ON PHYSICAL EXAMINATION FORM.

HEALTHCARE PROVIDER

Signature _____ Name _____

Address _____

Phone () _____ Date _____ License # _____

Please return this form by July 1 by mail, email, OR fax.

Health Service Box 17, Vassar College, 124 Raymond Avenue, Poughkeepsie, NY 12604-0017

Phone: 845-437-5800 Fax: 845-437-7135 Email: health@vassar.edu

