

# Vassar College

124 Raymond Avenue Box 17 Poughkeepsie New York 12604

Please contact us at [health@vassar.edu](mailto:health@vassar.edu) for any questions/concerns.

This form must be submitted **DIRECTLY TO THE HEALTH SERVICE** by July 1.

You should schedule a visit with your primary care provider as soon as possible so that your forms can be returned by the due date.

## MEDICAL FORM PART I — to be completed by student

Please complete all areas - form will be returned if not completed in full.

Please do not separate form - no partials please.

### MEDICAL HISTORY INFORMATION

**To the Student:** Each entering student is required to provide the following Medical History. Before enrolling you must also have a physical exam and immunization history completed and signed by your physician. This information is for Health Service use only and will not be released without your knowledge and consent. Please complete Part I of the Medical Form and then have your physician complete Part II – The Physical Examination and Immunization History. **Please print. All information must be in English.**

Name	Gender	Date of Birth
Home Address	Social Security number	
City	State	Zip Code
Student cell phone	Home phone	
Persons to contact in case of emergency (required):		
Name	Relationship	Name
Home Address	Relationship	Home Address
City	State	City
Home phone	Business phone	Cell phone
		Current email address (for contact over the summer)

### FAMILY HISTORY:

	Age	State of Health	Occupation	Age at Death	Cause		Yes	No	Relationship
Father						Cancer			
Mother						Diabetes			
Siblings						Died suddenly under age 50			
						Heart disease			
						High blood pressure			
						Gastrointestinal disorders			
						Asthma			
						Seizures			
						Alcoholism, Depression or Mental Illness			
						Other chronic illness (describe on back)			

### PERSONAL HISTORY:

Give details for each “yes” (including date of occurrence) on back 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			DES exposure		
food			Faintness with exertion			Intestinal problems			Women:		
bees			Chest pain with exertion			Psychiatric disorders			absent periods		
other _____			High cholesterol			Depression/anxiety			severe cramps		

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)

Students may register for services with the Office of Disability and Support Services (Telephone 845-437-7584).

Are you allergic to any medications? Yes or No. If yes, please list:

Do you: smoke?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	How much and for how long?	_____
drink alcohol?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	How much and for how long?	_____
use drugs?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	How much and for how long?	_____

Have you ever received treatment for any of the above?

Please use this space to explain any answers from side one.

I affirm the above is complete and accurate. \_\_\_\_\_  
Student's Signature Date



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

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**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)

Print Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

For availability of the meningitis vaccine in your local area, please contact your family doctor, local health department or [www.meningitisvaccine.com](http://www.meningitisvaccine.com).

The Menactra vaccine is offered at the Vassar College Health Service at a cost of \$95.

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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](http://www.nyhealth.gov); the Centers for Disease Control & Prevention, [www.cdc.gov/ncid/dbmd/diseaseinfo](http://www.cdc.gov/ncid/dbmd/diseaseinfo); and the American College Health Association, [www.acha.org](http://www.acha.org).

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**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

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**PHYSICAL EXAM** (must be within one year of admission)

Name \_\_\_\_\_  
Last First Middle Social Security Number 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) \_\_\_\_\_

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**REQUIRED: Tuberculosis Screening / Mantoux Test**

PPD (Mantoux) test (**within the past 12 months**)

Result: Neg \_\_\_ Pos \_\_\_ mm induration \_\_\_\_\_ Date Given: \_\_\_\_\_  
Month Day Year

Any positive reactors to TB screening — must provide written documentation by clinician. Date Read: \_\_\_\_\_  
Chest x-ray report and date \_\_\_\_\_ Month Day Year

(must be read within 48-72 hrs)

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.

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**HEALTHCARE PROVIDER**

Signature: \_\_\_\_\_ Address: \_\_\_\_\_

Name of physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Date: \_\_\_\_\_ Fax: \_\_\_\_\_

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

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ DATE: \_\_\_\_\_

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**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 1<sup>st</sup> dose and after age 15 months..... \_\_\_\_\_  
Month Day Year

If MMR given separately:

**MEASLES (Rubeola)** (check appropriate box)

1. Two doses of vaccine – the 1<sup>st</sup> dose after first birthday and the 2<sup>nd</sup> dose at least 28 days after the 1<sup>st</sup> 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
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**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

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**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



