Vassar College

124 Raymond Avenue Box 17 Poughkeepsie New York 12604

Please contact us at 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 asap 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 Nation (if not US)

Home phone

Student cell phone

Current email address (for contact over the summer)

Persons to contact in case of emergency (required):

Name Relationship

Home Address

City State

Home phone Business phone Cell phone

Name Relationship

Home Address

City State

Home phone Business phone Cell phone

FAMILY HISTORY:

	Age	State of Health	Occupation	(If deceased) Age at Death	Cause
Father					
Mother					
Siblings					

Cancer	Yes	No	Relationship
Diabetes			
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			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)

Students may register for services with the Office for Accessibility and Educational Opportunity (Telephone 845-437-7584).

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 from side one.

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 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) _____

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.

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 _____ Month Day Year Dose 2 _____ 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-Diphheria-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 PAPILLOMAVIRUS 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 original form by July 1 to:
Health Service, Vassar College, Box 17, 124 Raymond Avenue, Poughkeepsie, NY 12604-0017
Phone: 845-437-5800 Fax: 845-437-7135