Student Health Information

This form must be submitted directly to the Health Service by mail, email, or fax by July 1.

Please complete all sections. Please do not separate the sections. Incomplete forms and forms without the required signatures will be returned.

You should schedule a visit with your primary care provider ASAP so that your forms can be **returned by July 1.** Please keep a copy for your records. Contact us at health@vassar.edu with any questions or concerns.

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

Email
health@vassar.edu

Fax
845-437-7135

Medical Form Part 1 (to be completed by student)

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 (Last, First, Middle)

Gender / Pronouns

Date of Birth

Social Security Number

Permanent Address (Street)

Apt. Number

City

State

Zip

Nation (if not US)

Home Phone

Student Cell Phone

Email Address (for contact over the summer)

Emergency Contact 1 (required)

Name (Last, First)

Relationship

Home Address (Street)

City

State

Home Phone

Business Phone

Cell Phone

Email Address

Emergency Contact 2 (required)

Name (Last, First)

Relationship

Home Address (Street)

City

State

Home Phone

Business Phone

Cell Phone

Email Address

Family History

	Age	State of Health	Occupation	Age at death (if deceased)	Cause of death
Father					
Mother					
Siblings					

	Yes	No	Relationship
Cancer			
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 bottom of this form or attach a separate sheet if needed.
Do you have or have you ever had:

	Yes	No		Yes	No		Yes	No		Yes	No
Anemia			If you have an allergy, do you carry an epi-pen?			High cholesterol			Depression/anxiety		
Diabetes			Infectious mononucleosis			Joint disease/injury			Insomnia		
Thyroid problem			Chicken pox			Back problem/scoliosis			Anorexia/bulimia		
Sinusitis			Ear/nose/throat problem			Skin disorders			Operations:		
Bronchitis/ pneumonia			Visual problem			Tumor/cancer			Appendectomy		
Asthma			Hearing loss			Seizure disorder			Tonsillectomy		
Hay fever			Recurrent headaches			Jaundice/hepatitis			Hernia		
Allergies:			Head injury/concussion			Kidney disease			Overnight hospital		
Drugs			Heart problem			Bladder infections			Other chronic illness		
Food			High blood pressure			Stomach problems			Absent periods		
Bees			Faintness with exertion			Intestinal problems			Severe cramps		
Other			Chest pain with exertion			Psychiatric disorders					

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)

Are you allergic to any medications? If yes, please list:

- [ ] Yes
- [ ] No

Do you smoke? If yes, how much and for how long?

- [ ] Yes
- [ ] No

Do you drink alcohol? If yes, how much and for how long?

- [ ] Yes
- [ ] No

Do you use drugs? If yes, how much and for how long?

- [ ] Yes
- [ ] No

Have you ever received treatment for any of the above?

Student Signature Required

I affirm the above is complete and accurate. _____ _____

Student's Signature Date

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 Student Accessibility Form located in matriculation packet.)

Medical Authorization and Consent

Must be completed by all students.

For Student

I agree to allow the Medical Center/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's Signature

Print Name

Date

Parental Consent

For Parents

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 (please print name), _____ 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 the Medical Center/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

Meningococcal Meningitis Vaccination Response

New York State Public Health Law requires that all college students complete the following form.
Please see enclosed Meningococcal Meningitis Facts 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: (month/day/year) ___/___/___

☐ Menomune™
☐ Menactra™
☐ Trumenba™ / Bexsero™

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 Required by Student or Parent/Guardian

_____ _____

Student's Signature (or Parent/Guardian if student is a minor) Date

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.

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 2 (to be completed and signed by a Healthcare Provider)

All entering students are required to have a Physical Exam and to submit an Immunization History.
Both sections must be completed and signed by a Healthcare provider.

Physical Exam

Must be within one year of admission

Name (Last, First, Middle)

Gender / Pronouns

Height (in)

Weight (lbs)

☐ Overweight ☐ Underweight

Blood Pressure

Pulse

min.

Visual Acuity

OD: Near | OD: Far | OS: Near | OS: Far

Visual Acuity: Corrected

OD: Near | OD: Far | OS: Near | OS: 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)

Physician: please complete all pages

Tuberculosis Screening

Tuberculosis screening may be done either by Mantoux Test OR QuantiFeron-TB Gold blood test. QuantiFeron-TB Gold blood test is recommended for students who have received BCG. For either option, test must have been performed within the past 12 months.

Mantoux Test

Result (check below): ☐ NEG ☐ POS

mm Induration

Date Given: Month / Day / Year

Date Read (must be read within 48–72 hrs): Month / Day / Year

OR

QuantiFeron Gold

Results:

Date: Month / Day / Year

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

If positive – Chest x-ray report:

Date: Month / Day / Year

☐ Had INH Treatment

Date: 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: Fill out or stamp. Healthcare provider's signature is required.

Signature

Address

Name of physician

Telephone

Date

Fax

Physician: please complete all pages

Immunization History (to be completed and signed by a Healthcare Provider)

Note to the Healthcare Provider: If you elect to attach the immunization record in lieu of filling out the form, the immunization record must be stamped and signed.

Name | Date of Birth | 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

Dose 1: Given at age 12-15 months or later. Month / Day / Year

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

	Dose 1	Dose 2
☐ 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.	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 years if increased risk continues.)	Month / Day / Year
☐ Trumenba™ / Bexsero™	Month / Day / Year

Physician: please complete all pages

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)

Inavtivated (4 doses required)

Date Completed: / Day / Year

E Varicella (Chicken Pox)

History of disease:

Yes No

Immuniztion if given:

Dose 1 — Month / Day / Year

Dose 2 — Month / Day / Year

F Hepatitis B (Strongly Advised)

Immunization (Hepatitis B)

Dose 1 — Month / Day / Year

Dose 2 — Month / Day / Year

Dose 3 — 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)

Dose 1 — Month / Day / Year

Dose 2 — Month / Day / Year

or

Immunization (Combined Hepatitis A and Hepatitis B)

Completed series of immunizations: Month / Day / Year

H Quadrivalent Human Papillomavirus Vaccine (HPV)/(Gardasil 9) (If Given)

Dose 1 — Month / Day / Year

Dose 2 — Month / Day / Year

Dose 3 — Month / Day / Year

Physician: please complete all pages

I **Other**

J **Tuberculosous Screening**
Required within the past year. Please document on Physical Examination form.

Healthcare Provider: Fill out or stamp. Healthcare provider's signature is required.

Signature

Address

Name of physician

Telephone

Date

Fax

Additional Notes:

Please return this form by July 1 by mail, email, or fax to:
Health Service Box 17, Vassar College, 124 Raymond Avenue, Poughkeepsie, NY 12604
Phone (845) 437–5800 Fax (845) 437–7135 Email: health@vassar.edu

Physician: please complete all pages