

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	Vassar ID #
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Legal Name (if different from above)	Chosen Name		
<input type="text"/>	<input type="text"/>		
Permanent Address (Street)			Apt. Number
<input type="text"/>	<input type="text"/>		<input type="text"/>
City	State	Zip	Nation (if not US)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Home Phone	Student Cell Phone	Email Address (for contact over the summer)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

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		Yes	No	Relationship
Parent						Cancer			
Parent						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 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		
Diabetes			Infectious mononucleosis			Joint disease/injury			Anxiety		
Thyroid problem			Chicken pox			Back problem/scoliosis			Insomnia		
Sinusitis			Ear/nose/throat problem			Skin disorders			Anorexia/bulimia		
Bronchitis/pneumonia			Visual problem			Tumor/cancer			Operations:		
Asthma			Hearing loss			Seizure disorder			Appendectomy		
Hay fever			Recurrent headaches			Jaundice/hepatitis			Tonsillectomy		
Allergies:			Head injury/concussion			Kidney disease			Hernia		
Drugs			Heart problem			Bladder infections			Overnight hospital		
Food			High blood pressure			Stomach problems			Other chronic illness		
Bees			Faintness with exertion			Intestinal problems			Absent periods		
Other			Chest pain with exertion			Psychiatric disorders			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)

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?

Have you been diagnosed with COVID-19?

- Yes No

If you require academic, housing and/or meal plan accommodations 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 aeo@vassar.edu or 845-437-7584 to review your needs and establish your registration. (See Student Accessibility Form located in matriculation packet.) For further details and documentation guidelines, please visit the website at: (<https://accessibilityandeducationalopportunity.vassar.edu>.)

Student Signature Required

I affirm the above is complete and accurate.

Student's Signature

Date

Medical Authorization and Consent

Must be completed by all students.

For Student

I agree to allow the MidHudson Regional 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 and that Vassar College Medical Staff are acting in this capacity as my primary medical care providers.

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 MidHudson Regional 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 and that Vassar College Medical Staff are acting in this capacity as my primary medical care providers.

Parent/Guardian Signature

Print Parent/Guardian Name

Date

Meningococcal 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 immunization within the past 5 years.
The vaccine record is attached.

Note: The Advisory Committee on Immunization Practices recommends that all first-year college students up to age 21 years should have at least 1 dose of Meningococcal ACWY vaccine not more than 5 years before enrollment, preferably on or after their 16th birthday, and that young adults aged 16 through 23 years may choose to receive the Meningococcal B vaccine series. College and university students should discuss the Meningococcal B vaccine with a healthcare provider.

read, or have had explained to me, the information regarding meningococcal disease.
I (my child) will obtain immunization against meningococcal disease **within 30 days** from my private health care provider or Vassar College Health Service

read, or have had explained to me, the information regarding meningococcal disease.
I understand the risks of not receiving the vaccine. I have decided that I (my child) will **not** obtain immunization against meningococcal 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 and Bexsaro vaccines are 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

Legal Name (if different from above)

Pronouns

Height (in)

Weight (lbs)

Overweight

Underweight

Blood Pressure

Pulse

 min.

Head	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal (describe)	_____
Eyes	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal (describe)	_____
Ears	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal (describe)	_____
Nose	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal (describe)	_____
Throat	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal (describe)	_____
Neck	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal (describe)	_____
Chest	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal (describe)	_____
Lungs	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal (describe)	_____
Heart	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal (describe)	_____
Abdomen	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal (describe)	_____
Genitalia	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal (describe)	_____
Skin	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal (describe)	_____
Musculoskeletal	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal (describe)	_____
Neurological	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal (describe)	_____

Physician: please complete all pages

Tuberculosis Screening **REQUIRED**

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

Name of physician

Date

Address

Telephone

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.

Dose 2: Given at least 28
days after 1st dose and after
age 15 months.

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.

or
2. Had disease- confirmed by office record

or
3. Immunity demonstrated by titer

Dose 1

Dose 2

Mumps – Check appropriate box

1. One dose of vaccine after first birthday

or
2. Had disease- confirmed by office record

or
3. Immunity demonstrated by titer

Rubella – Check appropriate box

1. One dose of vaccine after first birthday

or
2. Immunity demonstrated by titer

B Meningococcal Vaccine (highly recommended)

Meningococcal Quadrivalent conjugate
(preferred (A,C,Y,W-135) 1 or 2 doses for all college students;
reactivate every 5 years if increased risk continues.)

Meningococcal Quadrivalent polysaccharide
(acceptable alternative if conjugate not available:
reactivate every 3–5 years if increased risk continues.)

MenB-RC
(Bexsero™)

MenB-FHbp
(Trumenba™)

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)

Inactivated (4 doses required)

Date Completed:

Month / Day / Year

E Varicella (Chicken Pox)

History of disease:

Yes No

Immunization 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

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

