Confidential Medical Report

Completion of this form is a requirement for matriculation to the college.

HOUGHTON COLLEGE

To maintain confidentiality, please return/mail directly to:

STUDENT HEALTH SERVICES, Houghton College,
One Willard Avenue, P.O. Box 128, Houghton, NY 14744
Phone: 585.567.9483, Fax: 585.567.4303

GENERAL INFORMATION

Please print

- *Physicians complete section 3 and portions of section 4. Students complete the remainder of the sections.*
- *Only students participating in East Meets West, Honors in London, and/or Highlander Wilderness Adventure need to complete the Off-Campus Studies form (sections 7 and 8). Note that a physician's signature is required on this form.*
- *Students anticipating participation in intercollegiate athletics must complete additional pre-participation forms. These forms are available on the Student Health Services website. Contact your coach for more information.*

Last name _____ First name _____ Middle name_____

Date of birth _____ Sex: M ☐ F ☐ Cell phone #_____

Home address (Street/P.O. Box) _____ E-mail_____

City_____ State/Province _____ Zip/Postal code_____ Country_____

_____
Parent/Guardian/Person to contact in case of emergency Tel. # Alt/Work Tel. #

_____
Alternate emergency contact Relationship Tel. # Alt/Work Tel. #

HEALTH INSURANCE

MANDATORY

Houghton College requires that all students taking at least 12 hours of credit provide proof of health insurance coverage. The college makes a reasonably priced, limited-benefit Accident and Illness Policy available to students who do not have insurance coverage otherwise. **The college program operates under an "opt out" policy, meaning that students will be enrolled in the college-negotiated policy automatically (and the charge for such will be applied to their student account) unless they submit a waiver providing information regarding alternate insurance coverage.** Please use the following site to obtain information about the college-offered plan and to opt out if desired: www.houghton.edu/students/student-health-services. Students should carry a copy of their insurance card for use on and off campus.

NOTE: Completing information on Off Campus form does <u>NOT</u> opt you out

AUTHORIZATION FOR TREATMENT

I hereby authorize Houghton College nursing and medical personnel to give and/or provide for medical and minor surgical care to (myself/my son/my daughter) upon (my/his/her) request and to arrange for such care as is necessary in the event of an emergency.

Student signature (if over age 18) _____ Date _____

Parent/guardian (if under age 18) _____ Date _____

Relationship _____

continued

Personal History

PLEASE CAREFULLY REVIEW AND COMPLETE THE FOLLOWING SECTIONS. Use another sheet if necessary.

Pediatrician/Family Physician_____ City _____ Phone _____ Fax _____

Do you see any specialists? ☐ Yes ☐ No Name_____ Specialty _____ Phone _____ Fax _____

MAJOR ILLNESS/INJURY

Please list any past medical problems, hospitalizations or other significant illness or illnesses.

ONGOING MEDICAL PROBLEMS

SURGICAL HISTORY

Please list any surgeries along with dates

MENTAL HEALTH HISTORY

Please list any past or present mental health issues with dates

CURRENT MEDICATIONS

Including prescription, over-the-counter, supplements and herbals taken routinely or as needed for a particular medical condition.

Please list with dosage

ALLERGIES

Please give approximate date of onset and type of reaction

Medications: _____

Food(s): _____

Environmental (insect stings, pollens, molds, etc.) _____

FAMILY MEDICAL/SURGICAL HISTORY

Please list significant medical conditions; if deceased, please note age and cause of death.

Mother: _____

Father: _____

Siblings: _____

Physical Examination

3.

To be completed by a physician, nurse practitioner or physician assistant.

Height _____ Weight _____ BP _____ Pulse _____

	WNL	Explanation/findings
1. Skin	_____	_____
2. Eyes	_____	_____
Vision: Corrected/uncorrected:	OD _____ OS _____ OU _____	
3. Ears, nose, throat	_____	_____
4. Respiratory	_____	_____
5. Cardiovascular	_____	_____
6. Gastrointestinal/hernia	_____	_____
7. Genito-urinary (as indicated)	_____	_____
8. Musculo-skeletal	_____	_____
9. Neuro	_____	_____

Is he/she under care for a chronic condition or serious illness? ☐ YES ☐ NO
(If yes, please include clinical report for continuity of care.)

Are there any contraindications to participation in all sports activities? ☐ YES ☐ NO *(If yes, please list restrictions.)*

LABORATORY TESTS

Necessary lab tests at discretion of examiner.

MANDATORY TB SCREENING

Was Section 5, Tuberculosis Screening reviewed by the student? ☐ Yes ☐ No

Based on risk assessment, is the student at risk for TB exposure? ☐ Yes ☐ No

If yes, one of these TB test is required within 6 months of admission.

PPD (Mantoux): Date placed _____, Date read _____, mm of induration _____

QuantiFERON® Date _____, Result _____

T-Spot® Date _____, Result _____

A chest x-ray is required if test is positive. Date _____, Result _____

Was treatment initiated? If yes, describe _____

PHYSICIAN AUTHORIZATION

Date of exam _____ Signature of examiner _____

Type or print name_____Are you the regular provider? ☐ YES ☐ NO

Phone (____)_____Address _____

City/town _____ State/country _____ Zip code _____

continued

Immunization Record

Certificate of Compliance with Immunization Requirements for Institutions of Higher Education in New York State

4.

Note: ***Part I & II must be completed and signed by student (parent/guardian if minor)***
Part III & IV must be completed and signed by a health care provider

Adapted from the American College Health Association's Vaccine-Preventable Disease Task Force in compliance with New York State Public Health law. /04

PART I

Full Name _____ Date of Birth _____/_____/_____
MM DD YYYY

PART II - Meningococcal Waiver

▶▶ REQUIRED BY NEW YORK STATE. ◀◀

Check One (1) Box Only and provide the necessary information:

☐ I have received the meningococcal vaccine ☐ Menactra (conjugated vaccine) Date ____/____
MM YYYY

☐ Menomune™ (Quadrivalent Polysaccharide vaccine) Date(s) ____/____ ____/____
MM YYYY MM YYYY

☐ I have read, or have had explained to me, the information regarding meningococcal disease in section 6. I understand the risks of not receiving the vaccine. I have decided that I (my child) will not obtain immunization against meningococcal disease.

SIGNED:_____ DATE:_____
(student or parent/guardian signature if student is under 18)

PART III - M.M.R. (MEASLES, MUMPS, RUBELLA)

To be completed and signed by your health-care provider. All information must be in English; see exemptions below.

A. M.M.R. — Documentation of two doses of measles, one dose of mumps, and one dose of rubella are **REQUIRED by N.Y.** unless proof of immunity is established by physician-certified disease or serological blood tests.

Check One (1) Box Only and provide the necessary information:

☐ Required immunizations received: Dose 1 (after first birthday) #1 _____/_____/_____
Dose 2 #2. _____/_____/_____

☐ History of disease (not acceptable for rubella): Measles _____/_____; Mumps _____/_____
A verification statement is required from the diagnosing physician, nurse practitioner, or physician assistant.

☐ Serological testing establishing immunity: ***Results must be attached***

Under NYS Public Health Law, exemption for the MMR requirements is allowable only in the following situations…

- Students born before January 1, 1957
- Medical Contraindications: A written, signed and dated statement from a physician must be provided citing the medical condition that contraindicates immunization, the expected duration of the exemption and the specific vaccine(s) being exempted.
- Religious exemption: A statement written, signed and dated by the student (or parent/guardian if the student is a minor) describing his/her objection to immunization based on religious tenets or practices. Philosophical objections are not acceptable.

PART IV - RECORD OF OTHER IMMUNIZATIONS

B. TETANUS-DIPHTHERIA
1. Primary series with DTaP or DTP: Primary series completed ___ /___
MM YYYY
2. Tetanus-Diphtheria (Td) booster within last 10 years: _____/_____
3. Tdap _____/_____ (ex Adacel)

C. POLIO Primary series completed ____ / ____ (IPV/OPV)
MM YYYY

D. Hepatitis B
1. Dose #1 _____/_____ Dose #2 _____/_____ Dose #3 _____/_____
2. Hepatitis B surface antibody: Date _____/_____ Result: Reactive____, Non-reactive____

E. Hepatitis A Dose #1 _____/_____ Dose #2 _____/_____

F. Varicella Verification of disease or vaccine Illness date _____ Vaccine date _____

G. Gardasil (HPV) Dose #1 _____/_____ Dose #2 _____/_____ Dose #3 _____/_____

H. Other immunizations: 1. Vaccine_____ Date(s) _____/_____, _____/_____

▶▶ ***I certify that the information in parts III and IV is accurate:*** ***HEALTH CARE PROVIDER SIGNATURE REQUIRED*** ◀◀

NAME: _____ SIGNATURE:_____

Tuberculosis (TB) Screening/Testing

Name _____

5.

Please answer the following questions:

Have you ever had a positive TB skin test?	○ yes ○ no
Have you ever had close contact with anyone who was sick with TB?	○ yes ○ no
Have you ever been vaccinated with BCG?	○ yes ○ no
Were you born in one of the countries listed below and arrived in the U.S. within the past 5 years?	○ yes ○ no
(if yes, please CIRCLE the country.)	
Have you ever traveled* to/in one or more of the countries listed below?	○ yes ○ no
(if yes, please CHECK the country/ies.)	

*The significance of the travel exposure should be discussed with a health-care provider and evaluated.

Afghanistan
Algeria
Angola
Argentina
Armenia
Azerbaijan
Bahrain
Bandladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cambodia
Cameroon
Cape Verde
Central African Republic
Chad
China
Colombia
Comoros
Congo
Cook Island
Cote d'Ivoire
Croatia
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
French Polynesia
Gabon
Gambia
Georgia
Ghana
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Japan
Kazakhstan
Kenya
Kribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Lativa
Lesotho
Liberia
Libyan Arab Jamahiriya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritius
Micronesia (Federated States of)
Mongolia
Montenegro
Morocco
Mozambique
Myanmar
Namibia
Nepal
Nicaragua
Niger
Nigeria
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Phillippines
Poland
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Saint Vincent and the Grenadines
Sao Tome and Principe
Senegal
Serbia
Seychelles
Sierra Leona
Singpore
Solomon Islands
Somalia
South Africa
Sri Lanka
Sudan
Suriname
Swaziland
Syrian Arab Republic
Tajikistan
Thailand
The former Yugoslav Republic of Macedonia
Timor-Leste
Togo
Tonga
Trinidad and Tobago
Tunisia
Turkey
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzebkistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2009. Countries with incidence rates of > 20 cases per 100,000 population. For future updates, refer to http://apps.who.int/ghodata/?vid=510

If the answer to any of the above questions is yes, Houghton College requires that a health-care provider assess the student's tuberculosis exposure risk. (to be completed within 6 months prior to the start of classes).

If the answer to all of the above questions is no, no further testing or further action is required.

What You Need to Know

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis. Hojas de Informacián Sobre Vacunas están disponibles en Español y en muchos otros idiomas. Visite http://www.immunize.org/vis

1. What is Meningococcal Disease?
Meningococcal disease is a serious bacterial illness. It is a leading cause of bacterial meningitis in children 2 through 18 years old in the United States. Meningitis is an infection of the covering of the brain and the spinal cord.
Meningococcal disease also causes blood infections.
About 1,000 – 1,200 people get meningococcal disease each year in the U.S. Even when they are treated with antibiotics, 10-15% of these people die. Of those who live, another 11%-19% lose their arms or legs, have problems with their nervous systems, become deaf, or suffer seizures or strokes.
Anyone can get meningococcal disease. But it is most common in infants less than one year of age and people 16-21 years. Children with certain medical conditions, such as lack of a spleen, have an increased risk of getting meningococcal disease. College freshmen living in dorms are also at increased risk.
Meningococcal infections can be treated with drugs such as penicillin. Still, many people who get the disease die from it, and many others are affected for life. This is why preventing the disease through use of meningococcal vaccine is important for people at highest risk.

2. Meningococcal Vaccine
There are two kinds of meningococcal vaccine in the U.S.:
• Meningococcal conjugate vaccine (MCV4) is the preferred vaccine for people 55 years of age and younger.
• Meningococcal polysaccharide vaccine (MPSV4) has been available since the 1970s. It is the only meningo-coccal vaccine licensed for people older than 55.
Both vaccines can prevent 4 types of meningococcal disease, including 2 of the 3 types most common in the United States and a type that causes epidemics in Africa. There are other types of meningococcal disease; the vaccines do not protect against these. Who should get meningococcalvaccine and when?

3. Routineaccination
Two doses of MCV4 are recommended for adolescents 11 through 18 years of age: the first dose at 11 or 12 years of age, with a booster dose at age 16.
Adolescents in this age group with HIV infection should get three doses: 2 doses 2 months apart at 11 or 12 years, plus a booster at age 16.
If the first dose (or series) is given between 13 and 15 years of age, the booster should be given between 16 and 18. If the first dose (or series) is given after the 16th birthday, a booster is not needed.
Other People at Increased Risk
• College freshmen living in dormitories.
• Laboratory personnel who are routinely exposed to meningococcal bacteria.
• U.S. military recruits.
• Anyone traveling to, or living in, a part of the world where meningococcal disease is common, such as parts of Africa.
• Anyone who has a damaged spleen, or whose spleen has been removed.
• Anyone who has persistent complement component deficiency (an immune system disorder).
• People who might have been exposed to meningitis during an outbreak.
Children between 9 and 23 months of age, and anyone else with certain medical conditions need 2 doses for adequate protection. Ask your doctor about the number and timing of doses, and the need for booster doses.
MCV4 is the preferred vaccine for people in these groups who are 9 months through 55 years of age. MPSV4 can be used for adults older than 55.

4. Some people should not get Meningococcal Vaccine or should wait.
• Anyone who has ever had a severe (life-threatening) allergic reaction to a previous dose of MCV4 or MPSV4 vaccine should not get another dose of either vaccine.
• Anyone who has a severe (life threatening) allergy to any vaccine component should not get the vaccine. Tell your doctor if you have any severe allergies.
• Anyone who is moderately or severely ill at the time the shot is scheduled should probably wait until they recover. Ask your doctor. People with a mild illness can usually get the vaccine.
• Meningococcal vaccines may be given to pregnant women. MCV4 is a fairly new vaccine and has not been studied in pregnant women as much as MPSV4 has. It should be used only if clearly needed. The manufacturers of MCV4 maintain pregnancy registries for women who are vaccinated while pregnant.
Except for children with sickle cell disease or without a working spleen, meningococcal vaccines may be given at the same time as other vaccines.

5. What are the Risks from Meningococcal Vaccines?
A vaccine, like any medicine, could possibly cause serious problems, such as severe allergic reactions. The risk of meningococcal vaccine causing serious harm, or death, is extremely small.
Brief fainting spells and related symptoms (such as jerking or seizure-like movements) can follow a vaccination. They happen most often with adolescents, and they can result in falls and injuries. Sitting or lying down for about 15 minutes after getting the shot – especially if you feel faint – can help prevent these injuries.
Mild problems
• As many as half the people who get meningococcal vaccines have mild side effects, such as redness or pain where the shot was given.
• If these problems occur, they usually last for 1 or 2 days. They are more common after MCV4 than after MPSV4.
• A small percentage of people who receive the vaccine develop a mild fever.
severe problems
• Serious allergic reactions, within a few minutes to a few hours of the shot, are very rare.

6. What if there is a moderate or severe reaction?
what should i look for?
Any unusual condition, such as a severe allergic reaction or a high fever. If a severe allergic reaction occurred, it would be within a few minutes to an hour after the shot. Signs of a serious allergic reaction can include difficulty breathing, weakness, hoarseness or wheezing, a fast heart beat, hives, dizziness, paleness, or swelling of the throat.
what should i do?
• Call a doctor, or get the person to a doctor right away.
• Tell your doctor what happened, the date and time it happened, and when the vaccination was given.
• Ask your provider to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form. Or you can file this report through the VAERS website at www.vaers.hhs.gov, or by calling 1-800-822-7967. VAERS does not provide medical advice.

7. The National Vaccine Injury compensation program
The National Vaccine Injury Compensation Program (VICP) was created in 1986.
Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling 1-800-338-2382 or visiting the VICP website at www.hrsa.gov/vaccinecompensation.

8. How can I learn more?
• Your doctor can give you the vaccine package insert or suggest other sources of information.
• Call your local or state health department.
• Contact the Centers for Disease Control and Prevention (CDC):
Call 1-800-232-4636 (1-800-CDC-INFO) or Visit CDC's website at www.cdc.gov/vaccines