Student Health Service

Winter 2015

Dear Students and Parents,

Attached are your required Medical History and Physical Exam Forms. This gives us important information and will allow us to provide health care during your Colgate career. Please return the forms directly to our office by January 15th so we can establish your medical chart.

Although all the requested information is important, we wish to emphasize the necessity of filling out the immunization history. The New York State Dept. of Health and Colgate University require primary and booster immunizations against the listed infectious diseases (A thru E) and Tuberculosis Screening (I). Those students with no immunization information or with inadequate immunizations (lack of booster shots) cannot attend classes until these shots have been completed. It is strongly recommended that you receive these vaccines before you arrive at Colgate, but if it is not possible, these and other vaccines are available at the Colgate Student Health Center (at cost). Also, New York State now requires that you complete Part II concerning Meningococcal disease. Please read the enclosed, important Meningitis handout.

You should also be receiving information about health insurance. The world of health insurance, especially when you are away from your hometown, is now complicated. We ask you to think about the various options before completing the web based waiver (deadline 1/15/16) at www.gallagherstudent.com/colgate. Many parents have found it informative to speak with a representative from their insurance carrier about out of area coverage. We ask that you submit a copy of the front and back of your insurance card and strongly recommend that students have a copy of the insurance card too.

Thank you for your cooperation. We are always available to answer your questions and look forward to meeting you later this year.

Merrill L. Miller, M.D.
Director, Student Health Services
TO INCOMING STUDENTS:

REPORT OF MEDICAL HISTORY (please print)

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
<th>Cell Phone #</th>
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</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Country (If not U.S.A.)</th>
<th>Zip + 4</th>
</tr>
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<tbody>
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<table>
<thead>
<tr>
<th>Gender</th>
<th>Date of Birth (Month / Day / Year)</th>
<th>SS#</th>
<th>Colgate Class Year</th>
<th>Colgate Student ID #</th>
</tr>
</thead>
<tbody>
<tr>
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Parent 1:

<table>
<thead>
<tr>
<th>Name</th>
<th>Home Address</th>
<th>Home Phone</th>
<th>Cell Phone #</th>
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</thead>
<tbody>
<tr>
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Business Address

<table>
<thead>
<tr>
<th>Business Phone</th>
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<td></td>
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</table>

Parent 2:

<table>
<thead>
<tr>
<th>Name</th>
<th>Home Address</th>
<th>Home Phone</th>
<th>Cell Phone #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

Business Address

<table>
<thead>
<tr>
<th>Business Phone</th>
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</tbody>
</table>

FAMILY HISTORY: Adopted: Yes ☐ No ☐

Have any of your relatives ever had any of the following:

- Diabetes
- Kidney Disease
- Heart Disease
- High Blood Pressure
- Blood Clots
- Cancer
- Epilepsy/Other Neuro

PERSONAL HISTORY: PLEASE ANSWER ALL QUESTIONS. Comment on all positive answers in space below.

Have you had? Yes No

<table>
<thead>
<tr>
<th>Malaria</th>
<th>Recurrent Headaches</th>
<th>Stomach or Intestinal Trouble</th>
<th>Chronic Cough</th>
<th>Shortness of Breath</th>
<th>ALLERGY TO: Penicillin/Ampicillin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuberculosis</td>
<td>Head Injury</td>
<td>Bladder Trouble</td>
<td>Hay Fever</td>
<td>Asthma</td>
<td>Cephalosporin</td>
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<tr>
<td>Mononucleosis</td>
<td>Wasting Sickness</td>
<td>Skin Problem</td>
<td>Allergy</td>
<td>Cancer</td>
<td>Sucks</td>
</tr>
<tr>
<td>Sinusitis</td>
<td>Fainting Spells</td>
<td>Urine Infection</td>
<td>Uterus Cancer (explain)</td>
<td>Insect Bites</td>
<td>Other (explain)</td>
</tr>
<tr>
<td>Eye Trouble</td>
<td>Patellar Tendon Fracture</td>
<td>Kidney Problems</td>
<td>Appendectomy</td>
<td>Other (explain)</td>
<td>FEMALES ONLY: Severe Cramps</td>
</tr>
<tr>
<td>Ear Infections</td>
<td>Heart Murmur</td>
<td>Rheumatoid Arthritis</td>
<td>Appendectomy</td>
<td>Other (explain)</td>
<td>Excessive Flow</td>
</tr>
<tr>
<td>Throat Infections</td>
<td>Rickets</td>
<td>Sickle Cell Anemia</td>
<td>Other (explain)</td>
<td>Other (explain)</td>
<td>Excessive Flow</td>
</tr>
<tr>
<td>Insomnia</td>
<td>Recurrent Weight Changes</td>
<td>Seizures</td>
<td>Hemodialysis</td>
<td>Other (explain)</td>
<td>Excessive Flow</td>
</tr>
<tr>
<td>Frequent Anxiety</td>
<td>Hemophilia</td>
<td>Weakness</td>
<td>Other (explain)</td>
<td>Other (explain)</td>
<td>Excessive Flow</td>
</tr>
<tr>
<td>Frequent Depression</td>
<td>Hypertension</td>
<td>Depression</td>
<td>Other (explain)</td>
<td>Other (explain)</td>
<td>Excessive Flow</td>
</tr>
</tbody>
</table>

REMARKS OR ADDITIONAL INFORMATION:

Has your physical activity been restricted during the past five years? Yes No

Have you received treatment or counseling for mental health issues such as depression, anxiety, attention deficit or an eating disorder? Yes No

Have you been hospitalized other than already noted? Yes No

Do you have any concerns about eating or weight? Yes No

Are you currently on any long-term medication? Yes No

Do you currently get allergy shots? Yes No

SPECIAL NEEDS

Do you have any special needs that the University should consider, in order to provide assistance with living and learning conditions? Yes No

☐ Hearing ☐ Allergies ☐ Motor Deficits ☐ Dietary ☐ Vision ☐ Learning ☐ Speech ☐ Psychological ☐ Other

Describe:

Lynn Waldman, Director of Disability Services, is available to discuss your concerns. Phone 315/228-7375 or e-mail jwaldman@colgate.edu.

I certify that, to the best of my knowledge, this information is correct. CONSENT FOR TREATMENT: The staff of the Colgate University Student Health Service has my permission for care and treatment. This may additionally include care and treatment by any hospital, surgeon, physician, or radiologist deemed necessary for appropriate medical, psychiatric, and or surgical treatment. If under 18, parent/guardian must sign.

Student’s Signature (parent/guardian if under 18) Date

Physician’s Signature (Acknowledging Review) Date

5/2015
TO THE EXAMINING HEALTH CARE PROVIDER: Please review the student's history and complete this form. Please comment on all positive answers.

THIS STUDENT HAS BEEN ACCEPTED. The information supplied will not affect the student's status: it will be used only as a background for providing health care. This information is strictly for the use of the Health Services and will not be released without student consent.

Name: ___________________________ DOB: ___________ was examined on this date: ___________________________

Physical Exam was Normal: Y N Comments: ____________________________________________________________

Physical activity: Unlimited Limited (explain): __________________________________________________________


WAS THIS WITH CORRECTIVE LENSES? Y N

RECENT LAB RESULTS: ALLERGIES: CURRENT MEDICATIONS:

Please note any health problem, chronic health condition or disability:

Health care provider (M.D., D.O., P.A., N.P., R.N., school health professional, health official) verifying the above must sign below.

Name (please print): ________________________________________________

Signature: ___________________________ Title: ___________________________ Date: ___________________________

Address: ___________________________ Phone: ___________________________ Fax: ___________________________
IMMUNIZATION RECORD

PART I — TO BE COMPLETED BY STUDENT (Please Print)

Name ___________________________ Last ___________________________ First ___________________________ M.I. ___________________________

Date of Birth (Month / Day / Year) _______/_____/______

Colgate Class Year _______________

New York State Public Health Law requires that all students born after December 31, 1996 be adequately immunized. You are legally required to provide this information and to get the necessary immunizations, or you will be DENIED enrollment. If you qualify for a medical or religious exemption, please complete Part IV.

Part II - Meningococcal Vaccine

As required by NYS Public Health Law, I have read or had explained to me, the information enclosed with this form about meningococcal disease. After choosing one of the following, the student or parent/guardian (if student under age 18) must sign below.*

___ I have had meningococcal vaccine: (if more than 5 years since Dose #1)

Dose #1 Date: ______/_____/______

Dose #2 Date: ______/_____/______

OR

___ I decline to receive the vaccine at this time and understand the risks.

Student or Parent/Guardian (if student under age 18) Signature ___________________________ Date ___________________________

PART III — TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER, GIVE MONTH, DAY & YEAR.

If convenient, you may attach a signed copy of your immunization records, which must include all previous and recent shots.

A. M.M.R. (Measles, Mumps, Rubella) (Two doses required.)

1. Dose 1 given at age 12-15 months or later. AND

2. Dose 2 given at age 4-6 years or later, and at least one month after first dose.

B. Tetanus-Diphtheria-Pertussis (Primary series with DtaP or DTP and booster in the last ten years meets requirement.)

1. Primary series of at least four doses with DtaP or DTP: #1 _______ #2 _______ #3 _______ #4 _______ #5 _______

AND

2. Tetanus-Diphtheria-Acellular Pertussis (Tdap) booster (one dose as an adult) _______

C. Polio (Primary series in childhood meets requirement.)

1. IPV/OPV: #1 _______ #2 _______ #3 _______ #4 _______

D. Varicella (Either a history of chicken pox, a positive Varicella antibody, or two doses of vaccine given at least one month apart, meets the requirement.)

1. History of Disease: No _______ OR Yes _______ (include date) _______

OR

2. Varicella antibody: Non-reactive _______ OR Reactive _______ (include date) _______

OR

3. Immunization: #1 _______ #2 (given at least one month after first dose) _______

E. Hepatitis B (Three doses of vaccine or a positive Hepatitis surface antibody meets the requirement.)

1. Immunization: #1 _______ #2 _______ #3 _______

OR

2. Hepatitis B surface antibody: Non-reactive _______ OR Reactive _______ (include date) _______

F. Quadrivalent Human Papillomavirus Vaccine (HPV) (Three doses of vaccine for males and females 11-26 years of age at 0, 2, and 6 month intervals.)

State, month, and year: #1 _______ #2 _______ #3 _______

G. Hepatitis A (Two doses, given at least 6 months apart, for those who travel to parts of the USA or other countries with high rates of Hepatitis A.)

State, month, and year: #1 _______ #2 _______

H. Other Other Immunizations (such as Pneumococcal, Meningococcal B, etc.):

I. Tuberculosis Screening -- SEE SEPARATE FORM

Health care provider (M.D., O.D., P.A., N.P., R.N., school health professional, health official) verifying the above must sign below.

Name (please print): ___________________________ Signature: ___________________________ Title: ___________________________ Date: ___________________________

Address: ___________________________ Phone: ___________________________ Fax: ___________________________

PART IV - STATEMENT OF EXEMPTION TO IMMUNIZATION LAW

IN THE EVENT OF AN OUTBREAK, EXEMPTED PERSONS WILL BE SUBJECT TO EXCLUSION FROM SCHOOL AND QUARANTINE.

MEDICAL EXEMPTION

The physical condition of the above named person is such that immunization would endanger life or health, or is medically contraindicated due to other medical conditions.

Signature of Physician ___________________________ Date ___________________________

RELIGIOUS EXEMPTION

Parent or guardian of the above named person or the person himself/herself adheres to a religious belief opposed to immunizations.

Student’s Signature (parent/guardian if under 18) ___________________________ Date ___________________________

Student Health Service
315/228-7750

5/2015
Part I To be completed by incoming students.

Student Name: __________________________ Last Name: __________________________ First Name: __________________________ M.I.: __________________________

DOB ______/_____/______

(PLEASE PRINT)

A) Have you had a previous positive TB Skin Test or IGRA Blood Test? □ No □ Yes

If No Proceed to Part B

□ Yes If yes, circle the test you had (TB Skin Test or IGRA Blood Test) and provide the following:

Date ______________ Result ______________ Date and Result of Chest X-Ray ______________

What treatment, if any, was started and when ______________

B) 1. Have you ever had close contact with persons known or suspected to have active TB disease? □ No □ Yes

2. Were you born in one of the countries listed below that have a high incidence of active TB disease? (If yes, please CIRCLE the country, below)

□ No □ Yes


3. Have you had frequent or prolonged visits* (more than 4 weeks) to one or more of the countries listed above with a high prevalence of TB disease? (If yes, CHECK the countries, above) □ No □ Yes

4. Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease (e.g., hospital, nursing home, or health clinic)? □ No □ Yes

5. Have you been a resident, employee, or volunteer at high-risk congregate settings (e.g., correctional facilities, long-term care facilities and homeless shelters)? □ No □ Yes

If the answer is YES to any of the above 5 questions, Colgate University requires that your Health Care Provider must complete Part II. See Part II (next page).

If the answer to all of the above 5 questions is NO and you were not born or traveled to a country listed above, no further testing or action is required and you do not need to have your Health Care Provider complete Part II.

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

Student Signature __________________________ Date __________________________
Colgate University Health Services
Required Tuberculosis (TB) Screening

Part II TO BE COMPLETED ONLY IF STUDENT ANSWERED YES TO ANY OF THE 5 QUESTIONS ON PART I SECTION B

Student Name: ____________________________  DOB ______/_____/______
(PLEASE PRINT)  Last Name  First Name  M.I.

Medical practitioner:
- Screening must be done within 6 months of the first day of classes.
- A student who has any positive risk factors must be tested for TB infection if there is no written documentation of a previous positive tuberculin skin test (TST) or Interferon gamma release assay (IGRA) (e.g. T-Spot, Quantiferon Gold).
- Previous BCG Immunization does not change TB screening requirements.

1. TB Symptom Check
Does the student have signs or symptoms of active pulmonary tuberculosis disease?  □ Yes  □ No
If no, proceed to 2 or 3.
If yes, check below and proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.
	□ Cough (especially if lasting for 3 weeks or longer) with or without sputum production
	□ Coughing up blood (hemoptyisis)
	□ Chest pain
	□ Loss of appetite
	□ Unexplained weight loss
	□ Night sweats
	□ Fever

(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0". The TST interpretation should be based on mm of induration as well as risk factors.)**
	Date Given: _____/_____/______  Date Read: _____/_____/______
	Result: ________ mm of induration **Interpretation:
	positive____  negative____

3. Interferon Gamma Release Assay (IGRA)
	Date Obtained: _____/_____/______  (QFT-GIT, T-Spot)
	Result: negative____  positive____  indeterminate____  borderline____ (T-Spot only)

4. Chest x-ray (Required if TST or IGRA is positive)
	Date Obtained: _____/_____/______
	Result: normal____  abnormal____

5. Please indicate any treatment given for positive TB testing: ____________________________

______________________________
Health care provider (M.D., D.O., P.A., N.P., R.N., school health professional, health official) verifying the above must sign below.

Name (please print): ____________________________
Signature: ____________________________  Title: ____________________________  Date: ____________________________
Address: ____________________________  Phone: ____________________________  Fax: ____________________________
Meningococcal Meningitis - possible to prevent - dangerous to ignore. There is a rare but sometimes deadly disease, called meningococcal meningitis, that strikes college students. The disease spreads quickly and within hours of the first symptoms can cause organ failure, brain damage, amputations of limbs, or death. Parents and students should learn more about meningococcal meningitis and consider immunization. Vaccination can prevent most cases of disease on college campuses.

Facts About Meningococcal Meningitis
* College students, particularly freshmen living in dormitories, have a higher risk of getting this contagious disease.
* Each year, the disease strikes about 2,500 Americans and 10 to 15 percent of them will die.
* Up to 20 percent of survivors have long-term disabilities, such as brain damage, hearing loss, or limb amputations.
* The disease can take one of two forms: swelling of the membranes that surround the brain and spinal cord, or the more deadly meningococccemia, an infection of the blood.
* Meningococcal meningitis is caused by bacteria called Neisseria meningitidis.

College Students at Special Risk
Overall, cases of this disease among adolescents and young adults have increased by nearly 60 percent since the early 1990s.

Lifestyle factors common among college students seem to be linked to the disease: crowded living situations such as dormitories, going to bars, smoking, and irregular sleep habits.

Freshmen living in dormitories are up to six times more likely to get the disease than other people.

Be Alert: Early Flu-Like Symptoms
Meningococcal meningitis is often misdiagnosed because its early signs are much like those of the flu or migraines. Symptoms may include high fever, headache, stiff neck, confusion, nausea, vomiting, and exhaustion.

Later, after the disease has taken hold, a rash may appear. If any of these symptoms are present and are unusually sudden and severe, call a physician or the college student health center. Don't wait.

How Meningitis Is Spread
The disease is spread through air droplets and direct contact with someone who's infected. That includes: coughing, kissing, and sharing cigarettes, utensils, cups, or lip balm — anything an infected person touches with his or her mouth.

Students can reduce their risk by considering vaccination and/or by not sharing certain things: utensils, beverages, cigarettes, etc.

Most cases occur in late winter or early spring when college students are away at school.

Consider Vaccination
Immunization can prevent up to 80 percent of meningococcal meningitis cases in adolescents and young adults:

* The vaccine is safe and effective against four of the five types of the bacteria responsible for meningococcal meningitis in the United States — and for the majority of cases in the college-age population.
* As with all vaccines, there may be minor reactions (pain and redness at the injection site or a mild fever).
* We strongly recommend that you receive this vaccine less than 5 years before starting college.

College Student Immunization Recommendations
The Centers for Disease Control and Prevention, American College Health Association, and American Academy of Pediatrics recommend that:
* College students and their parents should be told about the risk of meningococcal meningitis and the benefits of immunization.
* The vaccine should be made available to students who ask to be immunized.

Find Out More
For more information about meningococcal meningitis and the vaccine that can help prevent it, visit the following web sites:
* Meningitis Foundation of America, www.musa.org
* American College Health Association, www.achaa.org
* Centers for Disease Control and Prevention, www.cdc.gov

For medical advice about the meningococcal vaccine, consult your physician, college health service, or local public health department.

SUGGESTED ITEMS FOR YOUR COLLEGE "FIRST AID KIT":

- Band-aids
- Antibiotic Cream (Neosporin/Bacitracin)
- Hydrocortisone Cream
- Thermometer
- Pain Reliever Acetaminophen (Tylenol), Ibuprofen (Advil/Motrin)
- Cold Medicine/Decongestants
- Cough Drops/Cough Syrup
- Allergy Medicine/Antihistamine (Non Drowsy)
- Sore Throat Medicine (Lozenges/Chloraseptic)
- Antacid/Antigas Tablets or Liquid
- Prescription Medications & Lockbox
- Contact Lens Solution
- Hot/Cold Packs
- Humidifier
- Tissues
- Disinfectant Spray
- Hand Sanitizer