Confidential Medical and Immunization Report

TO BE COMPLETED BY STUDENT AND MEDICAL PROVIDER

Completion of this form and submission to the Health Center is required before matriculation at the college.

Deadlines for submission:
AUGUST 1 for FALL SEMESTER
DECEMBER 15 for SPRING SEMESTER
*Please allow 14 days for processing

Please return directly to:
STUDENT HEALTH SERVICES
PO Box 128, Houghton, NY 14744
Phone: 585.567.9483. Fax: 585.567.4303

STUDENT DEMOGRAPHIC INFO

Last name:_____ First name: _____ Middle name: _____

Date of birth: _____ Gender: ☐ M or ☐ F
Address: _____ City_____ State _____ ZIP:_____
Primary phone: _____ Alternate phone: _____ Email: _____

EMERGENCY CONTACT INFORMATION: PARENT or GUARDIAN

Name: _____ Relation to you _____
Address: _____ City_____ State _____ ZIP:_____
Primary phone: _____ Alternate phone: _____ Email: _____

ALTERNATE CONTACT:

Name: _____ Relation to you _____
Address: _____ City_____ State _____ ZIP:_____
Primary phone: _____ Alternate phone: _____ Email: _____

HEALTH INSURANCE REQUIREMENT and CURRENT COVERAGE INFORMATION:

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, ACA-compliant 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.

Insurance Co: _____ Phone # _____
Name of Insured: _____ Relation to you _____
Subscriber ID # _____ Insurance Group Number _____

❑ **I have enclosed a copy of my current health insurance card**
NOTE: Completing this form and submitting your card does NOT automatically opt you out of the college-offered plan. You still need to opt out on the web waiver site: www.houghton.edu/students/student-health-services.

AUTHORIZATION FOR TREATMENT: Please sign below to give college medical staff permission to to provides medical care.

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: _____ Date_____

Parent/guardian (if under age 18) :_____ Date_____

Name: _____ Date of Birth: _____

PERSONAL HEALTH HISTORY: To be completed by student & reviewed/confirmed by the Physician.

CURRENT MEDICAL PROVIDERS:

Family physician/Pediatrician: _____ Phone: _____

Specialist (s):_____ Phone: _____

_____ Phone: _____

PAST MEDICAL HISTORY:	Yes	No	**If yes, please give details… attach addtnl page if needed**
Do you have any ongoing/**chronic medical conditions**?			
Have you ever been **hospitalized or had a significant injury or illness**?			
PAST SURGICAL HISTORY:	Yes	No	
Have you ever had surgery?			
PAST MENTAL HEALTH HISTORY:	Yes	No	
Have you ever been treated **for depression or anxiety?**			
Have you ever been treated for **any other mental health problems**?			
MEDICATIONS:	Yes	No	
Do you take any **prescription medications**?			
Do you take any **OTC meds/supplements** regularly?			
ALLERGIES:	Yes	No	
Do you have any allergies to **medications**?			
Do you have any allergies to **insects/insect stings**?			
Do you have any **food** allergies?			
Do you have any **environmental** allergies?			
HEALTH RELATED HABITS:			
On average, about how many hours of **sleep** do you get a night? (Circle)	<5 5 6 7 8 9 >9		
On average, about how many days of the week to you get **exercise**?	<3 3 4 5 >5		
Do you currently use/or have you used in the past….	Yes	No	
Tobacco in any form (cigarettes, chew, etc.)?			
Alcohol? (If yes, note frequency..)			
Other substances?			
FAMILY HISTORY: Any significant medical history? If so, please provide details…			
Mother:			
Father:			
Siblings:			
ADDITIONAL QUESTIONS:	Yes	No	
Are you planning to participate in intercollegiate athletics?			
If yes, what sport will you be participating in?			
Have you ever passed out during or after exercise?			
Have you ever had chest pains during or after exercise?			
Have you ever had racing of your heart or "skipped beats?"			
Have you ever been told you have a heart murmur?			
Have you ever had high blood pressure?			
Have you ever had any tests done for your heart? (e.g. ECHO or EKG)			
Have you ever had a concussion?			
Have you ever had seizures or been diagnosed with epilepsy?			
Do you get frequent headaches or have a chronic headache syndrome?			
Have you ever had a broken bone, stress fracture or joint dislocation?			
Have you ever had an activity-limiting back or neck injury?			
Have you had COVID-19?			
If yes, please provide the date of your positive test			

Provider initials:

Name: _____ Date of Birth: _____

PHYSICIAN EVALUATION: To be completed by physician or other qualified medical provider…			**Date of Exam:**
PHYSICAL EXAMINATION:			**Allergies:**
VITALS:			
Height:_____ Weight: _____ BMI: _____ Pulse: _____ BP: _____/_____ (_____/_____) Vision (corrected): Right 20/ Left 20/			
MEDICAL SCREENING EXAM:	Normal	Abnormal	Comments
General appearance			
HEENT			
Lymph nodes			
Heart (standing and lying…)			
Pulses (especially femoral and radial…)			
Lungs			
Abdomen			
Skin			
Musculoskeletal			
Neuro			
Genitourinary (as indicated)			

TUBERCULOSIS (TB) SCREENING:	Yes	No	Comments
Was the accompanying **tuberculosis exposure risk assessment tool completed?**			
Based on your assessment of this student's risk, **is a TB test indicated?**			

If YES, then one of these TB tests is required within 6 months of arrival on campus:

PPD (Mantoux) : Date placed: _____ Date read: _____ Result: _____mm of induration

IGRA (e.g. QuantiFERON®): Date of test:: _____ Result: _____

If the TB test is POSITIVE, or if there is a history of PREVIOUSLY POSITIVE TESTING (or diagnosis of TB), then a chest X-ray is required…

Chest x-ray: Date of test:: _____ Result: _____

If the TB test was POSITIVE, was prophylactic treatment for LTBI initiated?			

PHYSICIAN ASSESSMENT:	Comments/recommendations for care while at college:
☐ Generally healthy ☐ No acute issues ☐ Chronic conditions are stable ☐ See specific comments…	

Please document clearance for participation in intercollegiate sports….

☐ Cleared without restriction.
☐ Cleared without restriction, with recommendation for further evaluation/treatment for ….
☐ Cleared with restrictions (please specify)…
☐ Clearance pending, requires documented follow-up of …
☐ Not cleared, due to ….

Comments:

Medical provider name and signature:_____ **Date:**_____

Address: _____ City_____ State _____ ZIP:_____
Office phone: _____ Office fax: _____

Immunization Report

You may also ask your doctor's office for their own report containing the information requested below. The information will be reviewed and you will be contacted if any information is incomplete.

Name: _____ Date of Birth: _____

IMMUNIZATIONS: Please provide the following information related to New York State immunization requirements….
To be completed/reviewed by your physician or other qualified medical provider.

MEASLES, MUMPS, and RUBELLA (MMR): New York State **requires** documentation of two doses of measles, one dose of mumps, and one dose of rubella **UNLESS** proof of immunity is established by physician-certified disease or serological blood tests.

Please check the appropriate box and provide the necessary information: (please only check one box)

☐ This student has received two (2) doses of the MMR vaccine. **Dates are noted below and confirmed on the attached immunization record.**

Date of dose 1: _____ **Date of dose 2:** _____

OR

☐ Serological testing establishes immunity **(Results must be attached)**

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

1. Students born before January 1, 1957
2. 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.
3. 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.

MENINGOCOCCAL VACCINE: New York State requires that all college students receive meningococcal vaccine within 5 years of entering college or sign a waiver specifically declining the immunization.

Please check the appropriate box and provide the necessary information: (please only check one box)

☐ This student has received meningococcal vaccine within the last 5 years. **Dates noted below and confirmed on the attached record.**

Menactra or Menveo Date of dose 1: _____ Date of dose 2: _____ and/or

Trumenba Date of dose 1: _____ Date of dose 2: _____. or
Bexsero Date of dose 1: _____ Date of dose 2: _____ Date of Dose 3: _____

OR

☐ This student has completed /signed the following waiver.
I have read, or have had explained to me, the information regarding meningococcal disease (see last page)
I understand the risks of not receiving the vaccine. I have decided that I (my child) will not obtain immunization against meningococcal disease.

Student signature:_____ Date:_____
(If under 18 years old, then parent or guardian must sign…)

COVID-19 VACCINE: If you have received the COVID vaccine, please provide the following information:

Type: _____ Date of dose 1: _____ Date of dose 2: _____

PHYSICIAN VERIFICATION of IMMUNIZATION STATUS:

I have reviewed the above information with the student and verify that s/he meets New York State immunization requirements.
In addition, I have reviewed and discussed this student's other routine immunizations and affirm that they are up-to-date or in the process of being updated…

☐ **Attached is an up-to-date printed immunization record (Required)**

Medical provider signature:_____ Date:_____
Medical provider name: _____

Name: _____ Date of Birth: _____

TUBERCULOSIS (TB) EXPOSURE EVALUATION: To be completed by student and reviewed/discussed with medical provider			
	Yes	No	Details
Have you ever been diagnosed with TB?			
Have you ever had a positive TB test in the past?			
If the answer to either of the questions is YES, please provide details of evaluation and treatment. **If the answers to both of these questions are NO, please answer the following screening questions:**			
SCREENING QUESTIONS:	Yes	No	Comments
Were you born in one of the countries listed below and arrived in the US within 5 years?			Please circle below
Have you traveled or lived in one of the countries listed below within the last year?			
Have you ever been in close contact with someone who had active TB?			
Have you ever used IV drugs?			
Have you volunteered or lived in any of the following settings within the last year?			
Hospital or nursing home			
Homeless shelter			
Prison or jail			
Alcohol or drug treatment center			
Do you take any immunosuppressive medications?			
Do you have a history of having any immunosuppressive medical conditions?			

Provider initials:

If the answer to ALL these questions is NO, then no further testing or other actions are required
If the answer to any of the questions is YES, then the medical provider should evaluate further and assess the student's need for TB testing.

Afghanistan
Algeria
Angola
Argentina
Armenia
Azerbaijan
Bahrain
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia
Bosnia/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 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
Kiribati
Kuwait
Kyrgyzstan
Laos
Latvia
Lesotho
Liberia
Libya
Lithuania
Macedonia
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritius
Micronesia
Mongolia
Montenegro
Morocco
Mozambique
Myanmar
Namibia
Nepal
Nicaragua
Niger
Nigeria
North Korea
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
St Vincent/Grenadines
Sao Tome and Principe
Senegal
Serbia
Seychelles
Sierra Leona
Singapore
Solomon Islands
Somalia
South Africa
Sri Lanka Sudan
Suriname
Swaziland
Syrian Arab Republic
Tajikistan
Tanzania
Thailand
Timor-Leste
Togo
Tonga
Trinidad and Tobago
Tunisia
Turkey
Turkmenistan
Tuvalu
Uganda
Ukraine
Uruguay
Uzebkistan
Vanuatu
Venezuela
Viet Nam
Yemen
Zambia
Zimbabwe

Meningococcal Disease and Vaccine

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.

Visit 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 meningococcal vaccine 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