CONFIDENTIAL MEDICAL REPORT (CMR): TO BE COMPLETED BY STUDENT AND MEDICAL PROVIDER

HOUGHTON UNIVERSITY

ALL STUDENTS are required to complete this form.

If you are participating in any of the following programs, please indicate by checking the boxes so information can be shared.

Check all that apply: ☐ Athletics ☐ Houghton Honors (London/Science) ☐ Highlander Wilderness Program

Students: Complete your portions of pages: 1-2 on your computer (or by hand if you prefer).
Then print out the entire document (single-sided only) and have your medical provider fill out the remaining required information.

After all pages are complete, scan and upload pages 1-4, along with a copy of the front and back your insurance card to:
Upload this CMR. Or https://forms.office.com/r/MNtTckAWg3. Or email a copy to healthcenter@houghton.edu

Deadlines for Submission: August 1 for the Fall Semester, December 1 for the Spring Semester. Please allow 14 days for processing.
Questions: Email the Health Center, Phone: (585) 567-9483, Fax: (585) 567-4303

STUDENT DEMOGRAPHIC INFO

Last Name: First Name: Middle Name:

Date of Birth: _ _ _ Gender: ☐ M ☐ F ☐

Address: City: State: Zip:

Student Cell 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:

Health insurance is REQUIRED for international students (excluding Canadians) and athletes taking at least 12 hours of credit.

All other students are strongly encouraged to carry health insurance (per federal regulations) but will not be required to provide proof of health insurance. Those not carrying health insurance will bear the cost of any accident or illness personally. The University is not responsible for covering these costs.

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.**

AUTHORIZATION FOR TREATMENT and AUTHORIZATION TO SHARE INFORMATION: Please sign below to give university medical staff permission to provide medical care and to share a copy of this form with other institutional offices that may need it for specific programs.

☐ ***I hereby authorize Houghton University 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.***

☐ ***I also hereby authorize Houghton University nursing and medical personnel to share a copy of this form, if needed, with the Athletic Department, Off-Campus Department and/or the Highlander Wilderness Program staff.***

Check all that apply: ☐ Athletics ☐ Houghton Honors (London/Science) ☐ Highlander Wilderness Program

Student Signature: **Date:**

Parent/Guardian (if student is under 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 additional 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? Or **food** intolerances	☐	☐	
Do you have any **environmental** allergies?	☐	☐	
HEALTH RELATED HABITS:			
On average, about how many hours of **sleep** do you get a night?	☐ <5	☐ 5	☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ >9
On average, about how many days of the week do 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 (last) positive test			

Provider initials:

Name: **Date of Birth:** _ _ _ _ _ _ _ _

THIS SECTION TO BE COMPLETED BY PHYSICIAN

PHYSICIAN EVALUATION: **To be completed by physician or another 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
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? Yes ☐ No ☐

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

Please document clearance for participation in: Intercollegiate Sports, Houghton Honors (London/Science), and/or Highlander Wilderness Programs

☐ 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: **Signature:** Date:

Address: City: State: Zip:

Office Phone: Office Fax:

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 University students receive meningococcal vaccine within 5 years of entering University 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: And/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)

TETANUS VACCINE: New York State requires that all University students receive a tetanus vaccine within 10 years of entering University or sign a waiver specifically declining the immunization.

This student has received a tetanus vaccine within the last 10 years. Dates noted below and confirmed on the attached record.

☐ Tdap Date of Dose:

☐ TD Date of Dose:

PHYSICIAN VERIFICATION of IMMUNIZATION STATUS:

I have reviewed the above information with the student and verify that she/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)** ***Provide student with a copy for their records**

Medical Provider Name: **Signature:** Date:

After all pages are complete, scan and upload pages 1-4, along with a copy of the front and back your insurance card to:
Upload this CMR. Or https://forms.office.com/r/MNtTckAWg3. Or email a copy to healthcenter@houghton.edu

Meningococcal Disease and Vaccine- KEEP THIS PAGE FOR YOUR INFORMATION: You do not need to upload this page.

What You Need to Know

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis. Hojas de Información 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. University 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 meningococcal 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. Routine Vaccination
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: • University 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 heartbeat, 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/vaccine