

Required Health History and Immunization Form

Health History Requirements

As a new student, you must submit a completed Health History and Immunization Form upon admission to the College.

The form, on pages three to five in this document, is the foundation of your medical record at SUNY Cortland. This record is reviewed by Student Health Service personnel and, if necessary, referred to the College physician for evaluation. It then is filed for reference to be used whenever a consultation for illness or a conference for health appraisal takes place. **All information is confidential and will be used only by Student Health Service.** You have been accepted and information you provide on this form will not be used to influence your status at SUNY Cortland.

Before your registration is considered final, the appropriate sections of this form must be completed by you and your clinician and mailed to Student Health Service. **If you are enrolling for the Fall semester the health form is due July 15. If you are enrolling for the Spring semester the health form is due Dec. 15.**

Please refer to the information on this page to see which health history, physical examination and immunization requirements apply to you.

Physical Examination Requirements

You are strongly encouraged to have a physical exam completed prior to arriving on campus. This allows a trusted family clinician to complete an updated physical exam as well as provide anticipatory counseling on issues related to college life.

Pre-admission physical examinations are required for the following students:

1. Intercollegiate athletes. Please be advised that you will not be allowed to try out for a team or to practice with a team until a pre-admission physical examination is completed. This physical exam must be completed within a year prior to admission if you are a new student and within three years of admission if you are a transfer student.

2. International students. This physical exam must be completed within a year prior to admission if you are coming from abroad and within three years of admission if you are a transfer student from a United States institution.

Required Immunizations

To comply with New York State's immunization laws, if you were born on or after Jan. 1, 1957, you will have to show adequate proof of immunization against measles, mumps and rubella. Proof of immunity consists of:

Measles — Two doses of live measles vaccine administered after 12 months of age, physician documentation of measles disease or a blood test showing immunity.

Mumps — One dose of live mumps vaccine administered after 12 months of age, physician documentation of mumps disease or a blood test showing immunity.

Rubella — One dose of live rubella vaccine administered after 12 months of age or a blood test showing immunity.

Recommended Vaccines

Please refer to the list below to see if you should receive these vaccinations. The recommendations are consistent with those of the Advisory Committee on Immunization Practices (ACIP) and the American College Health Association (ACHA).

Tetanus, Diphtheria, Pertussis — Most college students have completed a primary series in childhood. Tdap is recommended for the decennial booster dose for all college students.

Polio Vaccine — Most college students have completed a primary series in childhood. Boosters are given as needed for certain travelers over age 18.

Hepatitis A — Recommended for routine use in all adolescents through the age of 18 and in particular for high-risk individuals such as travelers to high-risk countries and persons with chronic liver disease.

Hepatitis B — Series of three doses given prior to college entry is strongly suggested for all college students. Sexually active persons are at high risk.

Influenza — This vaccine helps prevent students with certain medical conditions, such as asthma, from severe complications that can follow influenza. Other students may want to consider the vaccine to prevent disruptions in their activities during the school year. Vaccination clinics are held on campus each fall.

Meningococcal Tetravalent Vaccine — One dose of this vaccine is recommended for college freshmen living in residence halls, persons with terminal complement deficiencies or asplenia, laboratory personnel with exposure to aerosolized meningococci, and travelers to hyperendemic or endemic areas of the world. Non-freshmen college students under 25 years of age may choose to be vaccinated to reduce their risk of meningococcal disease. Please read the fact sheet included in this booklet.

Varicella Vaccine — This two-shot series for those over age 13 is strongly recommended for students without a history of chickenpox, age-appropriate immunization or with a negative antibody titer.

Recommended Screening

Tuberculin Skin Test — This is not a vaccine but a test to determine previous exposure to tuberculosis. This test is required for high risk students as defined by the Centers for Disease Control and Prevention (CDC). High-risk students include, but are not limited to, students who have arrived within the past five years from countries where tuberculosis is endemic, students with certain underlying medical problems and students who have worked in high-risk settings such as prisons or nursing homes. For more information, please refer to the CDC Web site at: www.cdc.gov

Return the completed Health History and Immunization Form to:

Student Health Service
Van Hoesen Hall, Room B-26
SUNY Cortland
P.O. Box 2000
Cortland, NY 13045

Meningococcal Disease Fact Sheet

What is meningococcal disease?

Meningococcal disease is a severe bacterial infection of the bloodstream or meninges — a thin lining covering the brain and spinal cord — caused by the meningococcus germ.

Who gets meningococcal disease?

Anyone can get meningococcal disease, but it is more common in infants and children. For some adolescents, such as first-year college students living in dormitories, there is an increased risk of meningococcal disease.

Every year in the United States approximately 2,500 people are infected and 300 die from the disease. Other persons at increased risk include household contacts of a person known to have had this disease, immunocompromised people, and people traveling to parts of the world where meningococcal meningitis is prevalent.

How is the meningococcus germ spread?

The meningococcus germ is spread by direct close contact with nose or throat discharges of an infected person.

What are the symptoms?

High fever, headache, vomiting, stiff neck and a rash are symptoms of meningococcal disease. The symptoms may appear two to 10 days after exposure, but usually within five days. Among people who develop meningococcal disease, 10 percent to 15 percent die, in spite of treatment with antibiotics. Of those who live, permanent brain damage, hearing loss, kidney failure, loss of arms or legs, or chronic nervous system problems can occur.

What is the treatment for meningococcal disease?

Antibiotics, such as penicillin G or ceftriaxone, can be used to treat people with meningococcal disease.

Should people who have been in contact with a diagnosed case of meningococcal meningitis be treated?

Only people who have been in close contact, such as household members, intimate contacts, health care personnel performing mouth-to-mouth resuscitation, day care center playmates, etc. need to be considered for preventive treatment. Such people are usually advised to obtain a prescription for a special antibiotic (rifampin, ciprofloxacin or ceftriaxone) from their physician. Casual contact, as might occur in a regular classroom, office or factory setting, is not usually significant enough to cause concern.

Is there a vaccine to prevent meningococcal meningitis?

In February 2005, the Centers for Disease Control and Prevention recommended a new vaccine, known as Menactra™, for use to prevent meningococcal disease in people 11-55 years of age. The previously licensed version of this vaccine, Menomune™, is available for children 2-10 years old and adults older than 55 years.

Both vaccines are 85 percent to 100 percent effective in preventing the four kinds of the meningococcus germ (types A, C, Y, W-135). These four types cause about 70 percent of the disease in the United States. Because the vaccines do not include type B, which accounts for about one-third of cases in adolescents, they do not prevent all cases of meningococcal disease.

Is the vaccine safe? Are there adverse side effects to the vaccine?

Both vaccines are currently available and both are safe and effective vaccines. However, both vaccines may cause mild and infrequent side effects, such as redness and pain at the injection site lasting up to two days.

Who should get the meningococcal vaccine?

The vaccine is recommended for all adolescents entering middle school (11-12 years old) and high school (15 years old), and all first-year college students living in dormitories. However, the vaccine will benefit all teenagers and young adults in the United States. Also at increased risk are people with terminal complement deficiencies or asplenia, some laboratory workers, and travelers to endemic areas of the world.

What is the duration of protection from the vaccine?

Menomune™, the older vaccine, requires booster doses every three to five years. Although research is still pending, the new vaccine, Menactra™, will probably not require booster doses.

How do I get more information about meningococcal disease and vaccination?

Contact your family physician or your student health service. Additional information also is available on the Web sites of the New York State Department of Health, www.health.state.ny.us; the Centers for Disease Control and Prevention www.cdc.gov/ncidod/diseases/index.htm; and the American College Health Association, www.acha.org.

July 2005. Source: New York State Department of Health, Bureau of Communicable Disease Control

Health History and Physical Examination

Name: _____
Last First Middle

Sex: Male Female Date of Birth: _____ Social Security Number: _____

Personal History

Have you had or are you now under treatment for any of the following problems? Check box if yes and provide a brief explanation in the space below.

- | | | |
|---|--|---|
| <input type="checkbox"/> Alcohol/Substance Abuse | <input type="checkbox"/> Disabling Condition | <input type="checkbox"/> Orthopedic Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Back Trouble | <input type="checkbox"/> Emotional Problem | <input type="checkbox"/> Splenectomy |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Epilepsy/Seizure Disorder | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Head injury/Concussion | <input type="checkbox"/> Tuberculosis or TB Contact |
| <input type="checkbox"/> Congenital or other heart problems | <input type="checkbox"/> Intestinal Disease | <input type="checkbox"/> Other |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | |

Operations, severe injuries and dates: _____

Medications taken at present? Yes No If yes, please list _____

Allergies? Yes No If yes, please explain _____

Family History (List all familial diseases: diabetes, tuberculosis, mental illness, other)

Physical Examination

Blood Pressure: _____ Pulse: _____ Height: _____ Weight: _____

Vision Far: Right 20/ _____ Far: Left 20/ _____ p with correction p without correction

	Normal	Abnormal		Normal	Abnormal
1. General Appearance			7. Abdomen		
2. Skin			8. Musculoskeletal		
3. HEENT			9. Psychiatric		
4. Neck			10. Other		
5. Lungs					
6. Heart					

Please provide a brief explanation of all items checked "abnormal." _____

Is this student able to participate in all physical activity, including intercollegiate athletics? * Yes No

If "No," what activities are to be eliminated? _____

If the student has one of a paired organ, have the risks of athletic participation been discussed with the student and parents? _____

What is your professional opinion of this applicant's ability to meet the physical and emotional demands of college? _____

*If the "No" box is checked, a letter will be sent to the student, the Physical Education Department, the Recreation and Leisure Studies Department and the Intramural Sports Office to inform them that until the student is seen at the Student Health Service, they may not participate in athletic activities. No specific health information will be released. This is done to ensure students' safe participation in activities of their choice.

Examining Physician: _____ Date: _____ Phone: _____

Signature Required

Immunization Requirements

PART I

Name: _____
Last First Middle

Date of Birth: _____ Social Security Number: _____

PART II Must be completed and signed by your health care provider. Dates must be provided in full (month/day/year).

Note: Measles, Mumps and Rubella immunizations dates or positive titres are required. You must complete **either** number 1,2 or 3.

	1st dose	2nd dose
1. Measles, Mumps, Rubella (MMR) Dose #1 given at age 12-15 months or later. Dose #2 given at age 4-6 years or later, and at least one month after dose #1. However, dose #2 can be given at any time if at least 28 days have elapsed since dose #1 and both doses are administered after one year of age.		
2. Measles #1 After first birthday and after 1/1/68 #2 After 15 months of age		
Mumps One dose live vaccine after first birthday		
Rubella One dose live vaccine after first birthday and after 1/1/69		
3. Copy of Serologic proof of Measles, Mumps and Rubella (if dates for measles, mumps and rubella immunizations are not available)		
4. Hepatitis B Immunization (suggested)	Date: #1	#2 #3
5. Hepatitis A (suggested for some)	Date: #1	#2
6. Varicella Vaccine (suggested if no history of the disease) Varicella Disease Date _____	Date: #1	#2
7. Tuberculin Skin Test (within six months) Required for high-risk students; see front page for information. If not high risk, please check here <input type="checkbox"/> International students are required to complete page six (<i>Tuberculosis Screening for International Students</i>).	Date:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative Please record millimeters induration If skin test is positive, write results of chest x-ray:
	1st dose	2nd dose 3rd dose 4th dose 5th dose Last booster
8. Tetanus, Diphtheria, Pertussis Three or more doses required. Most recent dose must be within 10 years. Please specify if later dose is Tdap.		
9. Polio Vaccine (suggested) Minimum of three doses for all students 18 and under.		
10. Meningococcal Tetravalent Vaccine Menactra-Tetravalent conjugate (preferred; data for revaccination pending): Date _____ Menomune-Tetravalent polysaccharide (acceptable alternative if conjugate not available; revaccinate every 3-5 years if increased risk continues): Date _____		

Health Practitioner: _____ Signature required Date: _____

Street: _____ City: _____ State: _____ Phone: _____

PART III - Meningitis Waiver To be completed only if the student **does not** have a valid vaccination for meningococcal disease. Students (or parent/guardian for student under the age of 18) must check box and sign below.

I have 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.

NOTE: Signing this **does not** prevent you (your child) from getting the meningococcal vaccine at a later date. Meningococcal vaccine is available at the Student Health Service. Please call (607) 753-4811 to request information about the current cost of the vaccine. You (your child) also may receive the vaccine from a family physician or other medical offices. If the vaccine is received at a later date, please report this information to the Student Health Service.

Signature: _____ Date: _____

Tuberculosis Screening¹ for International Students

(To be completed by international student's physician)

Name (please print) _____

Date of Birth _____

1. Does the student have signs or symptoms of active tuberculosis disease? Yes _____ No _____
If No, proceed to number 2. If Yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.

2. Is the student a member of a high-risk group as defined below²? Yes _____ No _____

If No, stop. If Yes, place tuberculin skin test (Mantoux only: Inject 0.1 ml of purified protein derivative (PPD) tuberculin containing five tuberculin units (TU) intradermally into the volar (inner) surface of the forearm.) A history of BCG vaccination should not preclude testing of a member of a high-risk group.

3. Tuberculin Skin Test:

Date Given: _____
month/day/year

Date Read: _____
month/day/year

Result: _____ (Record actual mm of induration, transverse diameter, if no induration, write "0")

Interpretation (based on mm of induration as well as risk factors): positive _____ negative _____

4. Chest x-ray (required if tuberculin skin test is positive) result: normal _____ abnormal _____
Please submit copy of written chest x-ray report to Student Health Service.

Health Care Provider

Name _____

Address _____

Signature _____

Phone (____) _____

¹The American College Health Association has published guidelines on tuberculosis screening of college and university students. These guidelines are based on recommendations from the Centers for Disease Control and the American Thoracic Society. For more information, visit www.acha.org or refer to the CDC's Core Curriculum on Tuberculosis available at state health departments or at the following Web site: www.cdc.gov/nchstp/tb/pubs/corecurr/.

²Categories of high risk students include those students who have arrived within the past five years from countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Therefore, students should undergo TB screening if they have arrived from countries EXCEPT those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia, USA, Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand. Other categories of high-risk students include those with HIV infection, who inject drugs, who have resided in, volunteered in, or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g., prednisone 15 mg/d for one month) or other immunosuppressive disorders.

Emergency Contact/Medical Insurance Information

For use by Student Health Service only, not campus-wide accessible.

Student Name: _____
Last First Middle

Date of Birth: _____ Social Security Number: _____

Address: _____
Street City State Zip

Parent or Guardian: _____

Home Phone: _____ Work Phone: _____

Address: _____
Street City State Zip

Primary Physician: _____ Phone: _____

Address: _____
Street City State Zip

Person to notify in case of emergency: _____ Relationship: _____

Address: _____ Phone: _____

Consent for Medical Care

To the Parents/Guardians of Applicants Under 18 Years of Age Only

In order to procure any necessary medical care and to protect the clinicians and institutions involved, please sign the consent for medical treatment below. Be assured that we make every effort to notify parents at once in case of major injuries or serious illnesses.

I (your full name), _____, pursuant to the authority vested in me as the parent/guardian of
(student's full name) _____

do hereby authorize the clinical staff at SUNY Cortland's Student Health Service to provide routine medical care to my son/daughter. This care may include treatment of common illnesses, physical examinations for sports participation, ordering of laboratory tests, prescribing of medications and the administration of immunizations to meet New York State immunization requirements. Furthermore, I do hereby authorize the clinical staff of the State University of New York College at Cortland to seek emergency medical care from outside clinicians if they feel it is necessary.

I understand that if my/son daughter participates in intercollegiate athletics, information about his/her medical condition and/or insurance coverage may need to be shared with the athletic training staff in order to ensure his/her safe participation in athletics. Any medical information not directly related to athletic participation will be kept confidential. My signature below includes authorization to release information to the athletic training staff as outlined above.

I understand I am free to withdraw this consent, in writing, at any time.

Signed: _____ Date: _____

Full Name (please print): _____

Insurance Information

All students are required to carry comprehensive health insurance, or purchase SUNY Cortland's Student Health Insurance Plan coverage. The Mandatory Health Fee supports direct health care services on the Cortland campus. It is not health insurance and does not cover the cost of laboratory studies, referral to outside clinicians or medications not provided by the Student Health Service. Unfortunately, many of our students are discovering their health insurance plans will not provide coverage for routine laboratory studies or medications outside their hometown areas. Students are encouraged to contact their insurance/health care plans prior to arrival on campus to be sure they understand what type of coverage they have while they are at SUNY Cortland. Please supply the information requested below.

Student Name: _____ Date of Birth: _____

Name of Insurance Company: _____

Address of Insurance Company: _____

Subscriber's Name: _____ Subscriber's Employer: _____

Subscriber's Social Security Number: _____ Subscriber's DOB: _____

Identification # (Include all letters and numbers): _____ Group Number: _____

If prior approval is needed for laboratory studies, referral or hospitalization, please provide student with necessary information so he/she may get approvals. The Student Health Service will not be responsible for obtaining prior approvals. NOTE: Giving insurance information on this form does not relieve students from the necessity to fill out an online health insurance waiver in order to waive the premium. Failure to complete an online waiver will result in the student being enrolled in the SUNY Cortland health insurance plan for the 2009-2010 year.

Required Health History and Immunizations

Completed records are due as soon as possible.
If you are enrolling for the Fall semester the health form is due July 15.
If you are enrolling for the Spring semester the health form is due Dec. 15.

Student Health Service
Van Hoesen Hall, Room B-26
SUNY Cortland
P.O. Box 2000
Cortland, NY 13045
Phone: (607) 753-4811
Fax: (607) 753-2486
Web: www.cortland.edu/sdc/hservices

