Mount Saint Mary College
330 Powell Avenue, Newburgh, NY 12550 • www.msmc.edu

Health Services Wellness Center
Phone: (845) 569-3152 Fax: (845) 569-3514

Medical History, Physical Examination and Immunization Form

MSMC policy requires that all entering full-time undergraduate students submit the following information to Health Services:

- ☐ Proof of Measles, Mumps, and Rubella Vaccination
- ☐ Proof of Meningococcal Meningitis Vaccination or Waiver
- ☐ Tuberculosis Screening
- ☐ Health History and Physical Examination

PLEASE READ THE FOLLOWING CAREFULLY BEFORE COMPLETING FORMS

The student, with the assistance of his/her parents, should complete items on pages 2 and 3, and sign page 2. This should be completed **before** your physical examination. **The health care provider must complete and sign pages 4 and 5.** This medical information is necessary to comply with New York State Law and will provide reference information in the event of a future illness. All information is confidential, and will be maintained in the Health Services Wellness Center office.

Measles, Mumps, and Rubella Vaccination Requirement

To comply with New York State's immunization laws, if you were born on or after January 1, 1957, you will have to show proof of immunity against Measles, Mumps, and Rubella. Your health care provider must complete and sign page 4.

Meningitis Vaccination or Waiver Requirement

New York State Public Health Law also requires our students to learn about meningitis and be aware of the availability of the meningitis vaccine (available at a cost from your health care provider). While you are not required to receive this vaccine, we strongly urge you to read the full information regarding meningitis included in this packet and to consider immunization. ***Please complete and sign the Meningitis Response section on page 4.***

New York State requires the college to dismiss any student who has not complied with the above two requirements 30 days from the first day of class.

Tuberculosis Screening and Physical Examination

A physical examination and tuberculosis screening (PPD test) must have been completed within the past calendar year.

Please return the completed form to:

MSMC – Health Services
330 Powell Avenue
Newburgh, NY 12550
Fax: (845) 569-3514

Any section of the form that is not complete will be returned to the student for completion. If you have any questions or concerns please do not hesitate to contact Health Services at (845) 569-3152 or healthservices@msmc.edu.

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PHONE 845-569-3152 **FAX** 845-569-3514
E-mail healthservices@msmc.edu

STUDENT HEALTH HISTORY FORM

All students must submit this completed form to Health Services

Student Contact Information

Name: _____ Birth Date: _____ / _____ / _____
Last *First* *Middle* *Month* *Day* *Year*

Permanent Address: _____ ☐ Male ☐ Female

City: _____ State: _____ ZIP: _____ Phone: (_____) _____

Cell Phone: (_____) _____

Date Entering MSMC: _____ / _____ / _____ Admission Status: ☐ Part Time ☐ Full Time Class of 20 ____ ____ ☐ New Student ☐ Transfer
Month *Day* *Year*

Health Practitioner:

Name: _____

Phone: (_____) _____ Fax: (_____) _____

Emergency Contact

Name: _____ Relationship: _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Health Insurance

Will you be covered by medical insurance while enrolled? ☐ Yes ☐ No

Policy Holder Name: _____ **Policy Holder** Birth Date: _____

Insurance Company Name: _____

ID/Policy Number: _____ Group Number: _____

Please ATTACH a copy of the front and back of your insurance card. We also suggest that students carry a current insurance card with them.

Accident Policy – All full-time undergraduate students are covered by an accident policy. You will receive a brochure outlining this policy.

Confidentiality and Authorization for Treatment

I certify the information that I have provided is truthful and I have no condition, limitation or restriction not mentioned in this document. I understand that this information is strictly confidential and will not be released to anyone without my written consent unless by court order. However, if I should be ill or injured and unable to sign the appropriate forms, I hereby give my permission to Mount Saint Mary College Health Services, when available, to release information from my health record to another provider(s), hospital or other medical agency involved in providing me with emergency treatment and/or medical care.

I authorize Mount Saint Mary College to provide care and treatment as deemed appropriate. This includes but is not limited to routine, urgent, emergency care, medication, immunization, diagnostic studies and referrals to hospitals, clinics and/or medical specialists deemed necessary by the college's medical and/or nursing staff. In the event of a life threatening emergency or serious illness/injury of which Health Services is aware, I authorize Health Services or college designee to notify my emergency contact.

_____ _____
Student Signature *Date*

_____ _____
Parent or Legal Guardian Signature (if student is under 18 years of age) *Date*

TO BE COMPLETED BY THE STUDENT BEFORE PHYSICAL EXAMINATION

Name: _____ Birth Date: _____ / _____ / _____
Last *First* *Middle* *Month* *Day* *Year*

Family History

Have any close relatives (parents, siblings) ever had any of the following?

Please check all that apply and indicate which relative the condition applies to

- ☐ Asthma _____
- ☐ Diabetes _____
- ☐ Heart Disease _____
- ☐ High Blood Pressure _____
- ☐ Hereditary Disorders _____
- ☐ Mental Illness _____
- ☐ Blood or Clotting disorders _____
- ☐ Cancer (please specify type) _____
- ☐ Thyroid Disease _____
- ☐ High Cholesterol _____
- ☐ Stroke _____
- ☐ Allergies _____
- ☐ Alcohol/Drug Dependency _____
- ☐ Other _____

Medical History

ALLERGIES: Do you have any allergies to: ☐ None ☐ Medications ☐ Food ☐ Environment

Please list all allergies and reaction: _____

MEDICATIONS TAKEN REGULARY: *(include birth control, inhalers, vitamins, antidepressants, allergy shots, pain control, diet pills)*

Medication/Dosage: _____

Medication/Dosage: _____

SURGERIES: ☐ None ☐ Appendectomy ☐ Tonsils/Adenoids ☐ Hernia ☐ Ear Tubes ☐ Other _____

INJURIES/HOSPITALIZATIONS: _____

CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES:

- ☐ None
- ☐ Decreased Hearing
- ☐ Vision Problems
- ☐ Fainting/Dizzy Spells
- ☐ Severe Head Injury/Concussion
- ☐ Sinus Problems – *chronic*
- ☐ Hay Fever/Seasonal Allergies
- ☐ Shortness of Breath
- ☐ Cough - *chronic*
- ☐ Asthma/Wheezing
- ☐ Pneumonia
- ☐ Chest Pain/Pressure
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Heartburn/GERD ☐ Peptic Ulcer
- ☐ Abdominal Pain – *chronic*
- ☐ Hepatitis/Jaundice
- ☐ Crohn's/Colitis ☐ IBD

- ☐ Painful Urination
- ☐ Increased Urination
- ☐ Urine Infections – *frequent*
- ☐ Sexually Transmitted Diseases
  Type: _____
- ☐ Bruise Easily ☐ Anemia
- ☐ Mononucleosis
- ☐ Cancer
  Type: _____
- ☐ Thyroid Disease ☐ Diabetes
- ☐ Seizures
- ☐ Headaches – *frequent*
- ☐ ADD/ADHD
- ☐ Arthritis/Rheumatism
- ☐ Bone Fracture/Joint Injury
- ☐ Neck/Back Pain ☐ Joint Pain
- ☐ Rhematic/Scarlet Fever
- ☐ Tuberculosis

- ☐ Acne ☐ Eczema
- ☐ Tattoos ☐ Piercings
- ☐ Depression ☐ Anxiety
- ☐ Self Injury/Cutting
- ☐ Eating Disorder
- ☐ History of Alcohol/Drug Addiction
- ☐ Emotional/Physical/Sexual Abuse
- ☐ Psychiatric Care or Counseling

SOCIAL HISTORY:

Do you now or have you ever consumed:

Cigarettes ☐ Y ☐ N
Pk./day _____
Alcohol ☐ Y ☐ N
Drinks/wk. _____
Caffeine ☐ Y ☐ N
Cups/day _____
Street Drugs ☐ Y ☐ N

SPORTS HISTORY: Have you ever…

- ☐ been restricted from sports or physical exercise?
- ☐ fainted during exercise?
- ☐ had chest pain or a racing heart during exercise ?
- ☐ wheezed or coughed during exercise?
- ☐ had a family member die of sudden death before age 50?
- ☐ had signs or symptoms of Marfans?

MALES: - *Please complete*

- ☐ Undescended testicle, testicular mass, lump

FEMALES: - *Please complete*

Menstrual flow:

☐ Reg. ☐ Irreg. ☐ Pain/Cramps

Days of Flow _____ Length of Cycle _____

Date of Last Pelvic Exam _____

OTHER: _____

_____

IMMUNIZATION RECORD

Must be completed and signed by health care provider OR attach immunization records signed by health care provider.

Name: _____ Birth Date: _____ / _____ / _____
Last *First* *Middle* *Month* *Day* *Year*

Required Immunizations

MMR (Measles, Mumps, Rubella)

New York State Public Health Law requires proof of immunization against Measles, Mumps, and Rubella.
Students born before January 1, 1957 are exempt from the MMR requirement.

Vaccination	Vaccine Date (Month/Day/Year)	Or Physician Diagnosed Disease (Date of Onset)	Or Serology Results/Date *Attach lab results &/or note if immune
2 MMR Dates **Dose #1** must be given on or after first birthday. **Dose #2** must be given after 15 months of age and at least 28 days after 1st dose. ***OR list individual vaccines below***	**#1** **#2**		
2 Measles Dates **Dose #1** must be given on or after first birthday. **Dose #2** must be given after 15 months of age and at least 28 days after 1st dose.	**#1** **#2**		*
1 Mumps Date **Dose #1** given on or after first birthday			*
1 Rubella Date **Dose #1** given on or after first birthday		**History of Rubella disease does not prove immunity**	*

Meningitis Information Response Form

New York State Public Health Law also requires our students to learn about meningitis and be aware of the availability of the meningitis vaccine. While you are not required to receive this vaccine, we strongly urge you to read the full information regarding meningitis (provided with this packet) and to consider immunization.

New York State Public Health Law requires you to select one of the statements below and provide your signature:

☐ I have received the immunization for meningitis within the past 10 years. **Date received:** _____

☐ I have read or had explained to me the fact sheet enclosed regarding meningococcal disease and am declining the vaccine at this time. I am fully aware of the risks associated with this disease, and of the availability and effectiveness of the vaccine.

_____ _____
Signature of Student (signature of parent/guardian if student is under 18 years of age) Date

Recommended Immunizations

Vaccines listed below are not required but are recommended. You may attach a copy of your immunization record from your health care provider.

Vaccination	Vaccine Date (Month/Day/Year)		
Hepatitis B Series of 3 doses	#1	#2	#3
Tetanus, Diptheria, Pertussis Dose within 10 years	Provide vaccine date and specify: ☐ Td ☐ Tdap		
Varicella Two doses, disease date or serology results	#1 #2	Disease Date	Serology date Attach lab results &/or note if immune

Health Care Practitioner Information Required (Physician, NP, PA)

_____ _____
Signature of Health Care Provider Date

_____ _____ _____
Print Name Phone Number of Practice Stamp of Health Care Provider

PHYSICAL EXAMINATION

Required within the past year (Must be completed by your health care provider)

Examiner: Please review the family/personal history and immunization record; complete this form and update any immunizations.

Name:			Birth Date:	
Height:	Weight:	BMI:	BP:	Pulse:

Distant Vision	Near Vision	Hearing Screen
Uncorrected / Corrected Vision L 20/ R 20/	Uncorrected / Corrected Vision L 20/ R 20/	☐ Pass ☐ Fail

Urinalysis *(required)* : Glucose _____ Specific Gravity _____ Blood _____ Albumin _____

Objective	Normal	Abnormal (describe)
General Appearance		
Skin		
Head/Ears/Eyes/Nose		
Mouth/Throat/Teeth		
Neck/Thyroid		
Lymph Nodes		
Lungs/Chest		
Heart/Pulses		
Abdomen		
Genitalia		
Back/Spine		
Neurological		
Musculoskeletal		

Assessment / Plan

1. General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
2. Is this student now under treatment for any medical or emotional condition? ☐ No ☐ Yes, please specify _____
   _____
3. Current Medications: _____
4. Immunizations Up to Date : ☐ Yes ☐ No Immunizations Given _____
5. Recommendation for Physical Activity (NCAA sports, club sports, intramurals)
   ☐ Unlimited ☐ Limited ☐ Disqualified If limited, please specify _____
6. Health Education: _____
7. Examiner's Comments/Other Recommendations: _____
   _____

Health Care Practitioner Information Required (Physician, NP, PA)

_____ Signature of Health Care Provider

_____ Date

_____ Print Name

_____ Phone Number of Practice

_____ Stamp of Health Care Provider

Tuberculosis Screening - REQUIRED within the past 12 months

TB Skin Test	Chest X-Ray	Medication Treatment
Date Planted: ___ / ___ / ___ (M D Y) Date Read: ___ / ___ / ___ (M D Y) Interpretation: ☐ Negative ☐ Positive _____ mm induration (If no induration, mark "0")	(Required if tuberculin skin test has a positive reaction) Chest X-Ray Date: ____ /____ /____ (M D Y) ☐ Normal ☐ Abnormal	Drug: _____ Dose/Frequency: _____ Treatment Completion Date: ___ / ___ / ___ (M D Y)

Signature of Health Care Provider: _____ **Date:** _____

Meningococcal Disease Fact Sheet

What is meningococcal disease?

Meningococcal disease is caused by bacteria called *Neisseria meningitidis*. It can lead to serious blood infections. When the linings of the brain and spinal cord become inflamed, it is called meningitis. The disease strikes quickly and can have serious complications including death.

Anyone can get meningococcal disease. Some people are at higher risk. This disease occurs more often in people who are:

- Teenagers or young adults
- Infants younger than one year of age
- Living in crowded settings like college dormitories or military barracks
- Traveling to areas outside of the United States, such as the "meningitis belt" in Africa
- Living with a damaged spleen or no spleen
- Being treated with Soliris® or who have complement component deficiency (an inherited immune disorder)
- Exposed during an outbreak
- Working with meningococcal bacteria in a laboratory

What are the symptoms?

Symptoms appear suddenly – usually 3 to 4 days after a person is infected. It can take up to 10 days to develop symptoms. Symptoms may include:

- A sudden high fever
- Headache
- Stiff neck (meningitis)
- Nausea and vomiting
- Red-purple skin rash
- Weakness and feeling very ill
- Eyes sensitive to light

How is meningococcal disease spread?

It spreads from person-to-person by coughing or coming into close or lengthy contact with someone who is sick or who carries the bacteria. Contact includes kissing, sharing drinks, or living together. Up to one in 10 people carry meningococcal bacteria in their nose or throat without getting sick.

Is there treatment?

Early diagnosis of meningococcal disease is very important. If it is caught early, meningococcal disease can be treated with antibiotics. But, sometimes the infection has caused too much damage for antibiotics to prevent death or serious long-term problems. Most people need to be cared for in a hospital due to serious, life-threatening infections.

What are the complications?

Ten to 15 percent of those who get meningococcal disease die. Among survivors, as many as one in five will have permanent disabilities. Complications include:

- Hearing loss
- Brain damage
- Kidney damage
- Limb amputations

What should I do if I or someone I love is exposed?

If you are in close contact with a person with meningococcal disease, talk with your health care provider about the risk to you and your family. They can prescribe an antibiotic to prevent the disease.

What is the best way to prevent meningococcal disease?

The single best way to prevent this disease is to be vaccinated. Vaccines are available for people 6 weeks of age and older.

Various vaccines offer protection against the five major strains of bacteria that cause meningococcal disease:

- All teenagers should receive two doses of vaccine against strains A, C, W and Y. The first dose is given at 11 to 12 years of age and the second dose (booster) at age 16.
    - It is very important that teens receive the booster dose at age 16 in order to protect them through the years when they are at greatest risk of meningococcal disease.
    - Talk to your health care provider today if your teen has not received two doses of vaccine against meningococcal strains A, C, W and Y.
- Teens and young adults can also be vaccinated against the "B" strain. Talk to your health care provider about whether they recommend vaccine against the "B" strain.

Others who should receive the vaccine include:

- Infants, children and adults with certain medical conditions
- First-year college students through 21 years of age living in residential housing
- People exposed during an outbreak
- Travelers to the "meningitis belt" of Sub-Saharan Africa
- Military recruits

Please speak with your health care provider if you may be at increased risk.

What are the meningococcal vaccine requirements for school attendance?

As of September 1, 2016, children entering grades 7 and 12 must be immunized against meningococcal disease strains A, C, W and Y according to the recommendations listed above.

Is there an increased risk for meningococcal disease if I travel?

- Meningococcal disease and outbreaks occur in the United States and around the world. The disease is more common in the "meningitis belt" of sub-Saharan Africa. The risk is highest in people who visit these countries and who have prolonged contact with local populations during an epidemic.
- To reduce your risk of illness, wash your hands often, maintain healthy habits such as getting plenty of rest and try not to come into contact with people who are sick.

Additional Information

- Travel and meningococcal disease
- Learn more about meningococcal disease (cdc.gov)
- More information about vaccine-preventable diseases

Source: New York State Department of Health, February 2016