

## Health and Immunization Record

### Section 1 – Personal Information - To be completed by student

 Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First

 Social Security No.: \_\_\_\_\_ Home Phone No.: (\_\_\_\_\_) \_\_\_\_\_  
Area Code

 Permanent Address \_\_\_\_\_  
Street Apt. #

 \_\_\_\_\_  
City State Zip

 Parent/Guardian/Emergency Contact \_\_\_\_\_  
Last First Relationship

 Address: \_\_\_\_\_  
Street City State Zip

 Phone Numbers: \_\_\_\_\_  
Home Work Cell

 Student's Primary Physician \_\_\_\_\_  
Last First Phone

 Address: \_\_\_\_\_  
Street City State Zip

Have you attended SUNY Cobleskill previously? Yes No If yes, last term attended \_\_\_\_\_

**Please note:**

- Incomplete information on any of this form will result in the entire form being returned to you for completion.
- Failure to submit a completed form will result in delays in the receipt of your official class schedule.
- We encourage you to keep a copy of this form for your records.
- Information contained in this form is accessible only by SUNY Cobleskill Health Services and Counseling Staff and will **not** be released without the written authorization of the student, or pursuant to a lawfully issued subpoena, per Section 355 of the Education Law.

**Important:**

- **Section 1 – Personal Information** – To be completed by student (p. 1-2)
- **Section 2 – Insurance Information** – To be completed by student and parent/policy holder (p. 3-4)
- **Section 3 – Immunizations & Physical** – to be completed by physician (p. 5-6)

**Please mail or fax all six pages together to:**

**SUNY Cobleskill Wellness Center**  
**130 Albany Avenue**  
**Cobleskill, NY 12043**  
**Fax: 518-255-5819**  
**Phone: 518-255-5225**

For Office Use Only	
	Complete
	_____
	Entered
	_____
	Card Sent
	_____

Student Last Name	First Name	ID#	DOB (mm/dd/yy)
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**Section 1 - Personal Health History – To be completed by student**

Please describe your general state of health by placing an 'X' in the appropriate box:	Yes	No
Do you have any food or drug allergies? If Yes, please describe: _____		
Are you taking any medication (including but not limited to birth control pills, over-the-counter medications, inhalers, vitamin/mineral supplements, borrowed medicines, and/or herbal remedies)? If yes, please include medication name, dose, and frequency: _____ _____		
Do you have, or have you ever had, a drug abuse or drinking problem?		
Are you currently being treated for any medical conditions? If yes, please describe:		
Are you currently in counseling and/or being treated for any psychiatric illnesses? If yes, please describe:		
Have you ever had any operations? If yes, please describe:		
Have you ever been hospitalized? If yes, please describe:		
Do you have an eating disorder? If yes, please describe:		
Are you, or have you been, a victim of physical or emotional abuse? If yes, please describe:		

**Please check the box next to any of the diseases or conditions you have had:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Anemia                     | <input type="checkbox"/> Heart problems/murmur           | <input type="checkbox"/> Poliomyelitis                      |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Hepatitis B or C                | <input type="checkbox"/> Rheumatic Fever                    |
| <input type="checkbox"/> Blood Transfusion          | <input type="checkbox"/> High Blood Pressure             | <input type="checkbox"/> Rheumatoid Arthritis               |
| <input type="checkbox"/> Bronchitis                 | <input type="checkbox"/> HIV                             | <input type="checkbox"/> Rubella                            |
| <input type="checkbox"/> Cancer                     | <input type="checkbox"/> Hives                           | <input type="checkbox"/> Scarlet Fever                      |
| <input type="checkbox"/> Chicken Pox                | <input type="checkbox"/> Infectious Jaundice/Hepatitis A | <input type="checkbox"/> Severe Injuries                    |
| <input type="checkbox"/> Colitis or Bloody Stools   | <input type="checkbox"/> Kidney Disease                  | <input type="checkbox"/> Sexually Transmitted Infections    |
| <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Malaria (Yellow Jaundice)       | <input type="checkbox"/> Sinusitis                          |
| <input type="checkbox"/> Ear Infection or Discharge | <input type="checkbox"/> Measles                         | <input type="checkbox"/> Speech Deficit                     |
| <input type="checkbox"/> Epilepsy                   | <input type="checkbox"/> Mononucleosis                   | <input type="checkbox"/> Thyroid Disease                    |
| <input type="checkbox"/> Eczema                     | <input type="checkbox"/> Mumps                           | <input type="checkbox"/> Tonsillitis                        |
| <input type="checkbox"/> Hay Fever                  | <input type="checkbox"/> Paralysis                       | <input type="checkbox"/> Tuberculosis (or positive TB test) |
| <input type="checkbox"/> Headaches                  | <input type="checkbox"/> Pneumonia                       | <input type="checkbox"/> Whooping Cough                     |
|   |  | <input type="checkbox"/> Other: _____                       |

**Family History**

	Mother	Father	Sibling	Sibling	Sibling	Sibling
General State of Health (Good, Fair, Poor, Deceased)						
Age (Present or at time of death)						
History of: (Place an 'X' in any applicable boxes)						
Tuberculosis						
Diabetes						
Kidney Disease						
Heart Disease						
Arthritis						
Gastrointestinal Diseases						
High Blood Pressure						
High Cholesterol						

Student Last Name

First Name

ID#

DOB (mm/dd/yy)

**Health Insurance Information**  
**Section 2 – To be completed by student and parent/policy holder**

**Required:**

- **A copy of the front and back of your health insurance card is required.** Please attach to this form. In case of emergency, students should always carry a copy of all insurance/prescription cards with them.
- Do you have health insurance coverage?    Yes        No

SUNY Cobleskill Accident & Sickness Insurance is automatically included on your tuition bill. If you do not have health insurance coverage it is required that you keep the Accident & Sickness Policy. Providing a copy of your health insurance card does not exclude you from the Accident & Sickness Insurance policy included on your tuition bill. **To remove this policy you must complete the Insurance Waiver form on page four**, stating that you have other health insurance coverage. This waiver can also be found at [www.cobleskill.edu/wellness](http://www.cobleskill.edu/wellness).

Health insurance coverage is required of all full time SUNY Cobleskill students. If you are already covered by health insurance you have the option of not participating in this health insurance plan. **Consider the following in making your decision:**

- Your current insurance may not provide coverage in the Cobleskill area (this includes but is not limited to HMO's, PPO's, HIP, and some Medicaid policies.) This may create hardship for you as a student, requiring you to travel to obtain medical services. We strongly encourage you to contact your health insurance company to investigate your coverage in the Cobleskill area. This is especially important if you are planning to be an athlete at SUNY Cobleskill.
- Coverage through parents' policies may end on a student's birthday (i.e. ages 19, 23, 25). If this will occur, you must keep the Accident & Sickness insurance.
- The minimal expense for the Accident & Sickness insurance will be well worth it if you find yourself under insured during the semester.

If, after careful consideration of the above, you wish to waive out of the Accident & Sickness Insurance please complete page four.

**CONFIDENTIALITY STATEMENT**

Student confidentiality is guaranteed at the Wellness Center. Information regarding student visits is not shared with family or others without the written permission of the student.

Student Last Name

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**SUNY Cobleskill  
Waiver Form  
Student Health Insurance Plan**

The Accident & Sickness Insurance policy is designed to meet the needs of students at a reasonable price and will supplement the services available at the Beard Wellness Center. Taking advantage of this offer may compliment the health insurance coverage or managed care you already have. Please consider the following in making your decision about waiving out of this policy:

- Your current insurance may not cover the types of expenses most frequently incurred by college age individuals such as outpatient referrals or may cover them only after a deductible or co-payment - this plan helps cover those expenses.
- **If your current coverage is through an HMO or PPO out of the Cobleskill area, services locally may be limited or may be charged to you at a higher rate. You need to contact your health insurance company to investigate your coverage in the Cobleskill area.**
- Coverage through parents' policies may end on a student's birthday, i.e. ages 19, 23 or 25
- This program provides an important level of coverage in addition to Medicare or Medicaid, if those are your only coverage, allowing greater flexibility and choice in the event of an illness.
- Coverage is available for dependents and/or part-time students by contacting: Beard Wellness Center
- Fall coverage: mid-August thru mid-January. Spring coverage: mid-January thru mid-August.

If, after careful consideration of the above items, you wish to remove the Student Accident & Sickness Insurance premium charge from your tuition bill, students must demonstrate that they are covered under another health insurance policy. Complete this waiver form and return it **with a copy of your health insurance card**, before semester check-in to: **SUNY Cobleskill Wellness Center, 130 Albany Avenue, Cobleskill, NY 12043** or fax to **518-255-5819**.

**I hereby waive participation in the Accident & Sickness Insurance program.** I certify that I have comparable coverage as indicated below. I acknowledge that I am legally responsible for any and all medical expenses incurred by myself/spouse/son/daughter while enrolled at SUNY Cobleskill. I understand that it is my responsibility to notify SUNY Cobleskill and to enroll in the Accident & Sickness Insurance Policy should my coverage cease at any point during enrollment at SUNY Cobleskill. A copy of my current health insurance card is attached and may be used in place of the below policy information

Student Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

ID# or SSN \_\_\_\_\_

Mailing Address \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_

Name of Insurance \_\_\_\_\_ Policy # \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ Relationship to Insured \_\_\_\_\_

Signature of Parent/Policy Holder \_\_\_\_\_ Date \_\_\_\_\_  
(Required)

Signature of Student \_\_\_\_\_ Date \_\_\_\_\_  
(Required)

Information regarding the Accident & Sickness Insurance policy can be found at [www.cobleskill.edu/wellness](http://www.cobleskill.edu/wellness)

The Accident & Sickness Insurance policy is a bi-annual policy. Failure to waive out of this policy through the use of this form will result in your being billed for coverage each semester. If you waive out and encounter a loss of other health insurance coverage, it is your responsibility to become enrolled in this policy. You may enroll in the Accident & Sickness Policy at any time during the semester by demonstrating proof of a change in your health insurance coverage. Waiving out of the policy can only occur at the beginning of a semester and should be done before your arrival on campus. You will be billed and responsible for payment if a completed waiver is not submitted prior to semester check-in. No waivers will be accepted later than **September 15<sup>th</sup>** for fall semester and **February 8<sup>th</sup>** for spring semester.

Student Last Name

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DOB (mm/dd/yy)

### Required Immunizations

#### Section 3 – To be completed by a licensed medical provider.

This information is required by all students enrolled in six credits or more.

**Required:**

- Two Measles vaccine doses
- One dose of Mumps vaccine
- One dose of Rubella vaccine
- Tuberculosis test
- Meningitis immunization or declination
- Tetanus Immunization (DPT/TD)
- Signature of a licensed medical provider

<b>MMR:</b> <u>Two doses are required</u> ; exempt if born before 1/1/57. Dose 1 given at age 12-15 months; Dose 2 given at age 4-6 or later, and at least one month after first dose.			<b>MMR #1:</b> _____ mm/dd/yy	<b>MMR#2:</b> _____ mm/dd/yy
<b>OR</b>				
<b>Measles #1:</b> _____ mm/dd/yy	<b>Mumps:</b> _____ mm/dd/yy If Mumps is given <u>instead</u> of MMR, must be given after 1 <sup>st</sup> birthday and 1969 or later.	<b>Rubella:</b> _____ mm/dd/yy If Rubella is given <u>instead</u> of MMR, must be given after 1 <sup>st</sup> birthday.		
<b>Measles #2:</b> _____ mm/dd/yy If Measles is given <u>instead</u> of MMR, both injections must be after 12/31/67 and after 1 <sup>st</sup> birthday.				
<b>OR</b>				
<b>Titer proving immunity to:</b> A copy of the result is required				
<b>Measles titer:</b> _____ mm/dd/yy	<b>Mumps titer:</b> _____ mm/dd/yy	<b>Rubella titer:</b> _____ mm/dd/yy		

  

<b>Tuberculosis Test:</b> PPD or Mantoux <u>Within 12 months prior to college entry.</u>  Do not return this form until the TB reading has been done.  If positive TB result, a chest x-ray is required.	<b>Date placed:</b> _____ mm/dd/yy	<b>Result:</b> _____ mm induration
	<b>Date read:</b> _____ (48-72 hours later) mm/dd/yy	
	<b>Chest X-ray date:</b> _____ mm/dd/yy	<b>CXR Results:</b> _____ Please attach copy mm/dd/yy
	If negative CXR and Positive PPD, was INH offered? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused If treatment given, state length of treatment/months and drug(s) used: _____	

  

<b>Meningococcal Meningitis</b> Please check one: <input type="checkbox"/> I have had the Meningitis vaccination on: _____ _____ or _____ Menomune (mm/dd/yy)      Menactra (mm/dd/yy)	<b>OR</b>	<input type="checkbox"/> I have read the Meningitis information (pg. 6) and decided I will not obtain immunization against the disease at this time.
<b>Signature required:</b> Student (if age 18 or older) Parent (if student is under 18)		

  

<b>DPT</b> Date series complete: _____ mm/dd/yy	<b>TD booster</b> _____ mm/dd/yy	or	<b>Tdap</b> _____ mm/dd/yy
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The immunization information on this page requires the signature of a licensed medical provider. A photocopy of a high school immunization record or other certified immunization document is acceptable.

Licensed Medical Provider Name	Provider signature	License #
Address		Phone #

## Optional Immunizations & Physical Exam

### Section 3 - To be completed by a licensed medical provider

**Recommended Immunizations:** Please discuss with your healthcare provider

<b>Hepatitis B</b> mm/dd/yy	#1	#2	#3	<b>Varicella</b> mm/dd/yy	#1	#2
<b>Gardasil</b> mm/dd/yy	#1	#2	#3			

**Physical Examination:** Strongly encouraged, but only required if you plan to participate in college sports

Gender:  Male  Female

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

B/P: \_\_\_\_\_

	Normal	Abnormal		Comments
<input type="checkbox"/>	<input type="checkbox"/>		HEENT	
<input type="checkbox"/>	<input type="checkbox"/>		Teeth and Gingiva	
<input type="checkbox"/>	<input type="checkbox"/>		Lungs, Chest and Breasts	
<input type="checkbox"/>	<input type="checkbox"/>		Cardiovascular	
<input type="checkbox"/>	<input type="checkbox"/>		Abdomen	
<input type="checkbox"/>	<input type="checkbox"/>		Ano-rectal	
<input type="checkbox"/>	<input type="checkbox"/>		Endocrine System	
<input type="checkbox"/>	<input type="checkbox"/>		Musculoskeletal	
<input type="checkbox"/>	<input type="checkbox"/>		Neurologic	
<input type="checkbox"/>	<input type="checkbox"/>		Psychiatric (specify deviations)	
<input type="checkbox"/>	<input type="checkbox"/>		Pelvic Exam (optional)	

This student may participate in all sporting activities.

Date of Exam: \_\_\_\_\_

\_\_\_\_\_  
Licensed Medical Provider Name

\_\_\_\_\_  
Provider signature

\_\_\_\_\_  
License #

#### MENINGOCOCCAL MENINGITIS FACTS

- **WHAT IS MENINGOCOCCAL MENINGITIS?** Meningococcal disease is a severe bacterial infection of the bloodstream or meninges (a thin lining covering the brain and spinal cord). It is a relatively rare disease and usually occurs as a single isolated event. Clusters of cases or outbreaks are rare in the United States.
- **HOW IS THE GERM MENINGOCOCCUS SPREAD?** Meningococcal disease is transmitted through the air via droplets of respiratory secretions and direct contact with an infected person. Direct contact, for these purposes, is defined as oral contact with shared items such as cigarettes or drinking glasses or through intimate contact such as kissing. Although anyone can come in contact with the bacteria that causes meningococcal disease, data also indicates certain social behaviors, such as exposure to passive and active smoking, bar patronage, and excessive alcohol consumption, may put students at increased risk for the disease. Patients with respiratory infections, compromised immunity, those in close contact to a known case, and travelers to endemic areas of the world are also at increased risk.
- **WHAT ARE THE SYMPTOMS?** The early symptoms usually associated with meningococcal disease include fever, severe headache, stiff neck, rash, nausea, vomiting, and lethargy, and may resemble the flu. Because the disease progresses rapidly, often in as little as 12 hours, students are urged to seek medical care immediately if they experience two or more of these symptoms concurrently. The disease is occasionally fatal.
- **HOW SOON DO THE SYMPTOMS APPEAR?** The symptoms may appear two to 10 days after exposure, but usually within five days.
- **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 (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 (either 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?** Presently, there is a vaccine that will protect against some of the strains of meningococcus. It is recommended in outbreak situations, and for those traveling to areas of the world where high rates of the disease are known to occur. For some college students, such as freshman living in dormitories, there is a modestly increased risk of meningococcal disease; students and parents should be educated about meningococcal disease and the availability of a safe and effective vaccine.
- **HOW EFFECTIVE IS THE VACCINE?** The meningococcal vaccine has been shown to provide protection against the most common strains of the disease, including serogroups A, C, Y and W-135. The vaccine has shown to be 85 to 100 percent effective in serogroups A and C in older children and adults.
- **IS THE VACCINE SAFE? ARE THERE ADVERSE SIDE EFFECTS TO THE VACCINE?** The vaccine is very safe and adverse reactions are mild and infrequent, consisting primarily of redness and pain at the site of injection lasting up to two days.
- **WHAT IS THE DURATION OF PROTECTION?** The duration of the meningococcal vaccine's efficacy is approximately three to five years.

\_\_\_\_\_  
Student Last Name

\_\_\_\_\_  
First Name

\_\_\_\_\_  
ID#

\_\_\_\_\_  
DOB (mm/dd/yy)