Health Information Form

Completion of this form is a requirement for students that are planning to attend on-campus courses taking 6 credit hours or more, and/or planning to live in college housing.

To maintain confidentiality, please return/mail all health forms directly to:

HEALTH SERVICES, Davis College
400 Riverside Drive, Johnson City, NY 13790
health@davisny.edu
Phone: 607.729.1581 ext. 337, Fax: 607.584.7656

General Information

Last Name ______________________________________ First Name ____________________________________ MI ______

Date of Birth ____________________ Sex: M ☐ F ☐ Height ______________ Weight ___________________

Home Address (Street/P.O. Box) _______________________________________ Email ___________________________________

City ___________________________________ State/Province __________ Zip/Postal Code ____________ Country ___________

Cell Phone # _____________________________________ Home Phone # ____

Anticipated date of registration: Fall 20______ Spring 20______

Emergency Contacts

____

Parent/Guardian/Person to contact in case of emergency Relationship Primary Phone # Alternate Phone #

____

Street Address/ PO Box City State Zip Code

____

Alternate emergency contact Relationship Primary Phone # Alternate Phone #

____

Street Address/ PO Box City State Zip Code

Family Medical History

Please check any box(es) that may apply to your father, mother, grandparents, and/or siblings.

Alcoholism	Yes ☐	No ☐	Diabetes	Yes ☐	No ☐	Mental Illness	Yes ☐	No ☐
Anemia	Yes ☐	No ☐	Drug Abuse	Yes ☐	No ☐	Stroke	Yes ☐	No ☐
Blood Trait	Yes ☐	No ☐	Heart Disease	Yes ☐	No ☐	Suicide	Yes ☐	No ☐
Cancer	Yes ☐	No ☐	High Blood Pressure	Yes ☐	No ☐	Tuberculosis	Yes ☐	No ☐

Personal History

Please carefully review and complete the following sections.
You may use another sheet if necessary.

Pediatrician/Family Physician ____

Address ____ City/State/ZIP _____________________________________

Phone # _______________________________________ Fax ____

Do you see any specialists? Yes ☐ No ☐ Name _____________________________ Specialty ___________________________

Address ____ City/State/ZIP_____________________________________

Phone # _______________________________________ Fax ____

Major Illness/Injury

Please list any past medical problems, hospitalizations, or other significant illnesses, including dates.

____

____

Ongoing Medical Problems

____

____

Surgical History

Please list any surgeries, including dates.

____

____

Current Medications

Including prescription, over-the-counter, supplements, and herbals taken routinely or as needed for a particular medical condition. Include dosages and times of day. Use separate page if needed

____

____

Have you ever abused or been dependent on drugs (prescription, illegal, recreational, or over the counter)? Yes ☐ No ☐

If yes, Specify __________________________ Treatment ______________________ When _____________________ Where ______________

Have you ever abused alcohol? Yes ☐ No ☐ If Yes, How long? __________________ Treatment ________________________________

Do you currently use tobacco in any form (chew, smokeless, e-cigarettes, hookah, etc.)? Yes ☐ No ☐ Specify ________________________

Mental Health History

Please list any past or present mental health issues, including dates.

____

____

Have you ever been diagnosed with a mental illness? Yes ☐ No ☐ If yes, specify ____

Have you ever received treatment/counseling for anxiety, eating disorder, personality disorder, or depression? Yes ☐ No ☐

Treatment _______________________________________ When ___________________________ Where _____________________________

Are you currently receiving counseling? Yes ☐ No ☐ Counselor Name ________________________ Phone ______________________

Allergies and Dietary Restrictions

Please give approximate date of onset and type of reaction.

Medications ____

Food(s) ____

Environmental (insects, animals, pollens, molds, etc.) ____

Do you carry an Epi-Pen? Yes ☐ No ☐

Additional Health Information

Please select the answer that best applies to your personal health.

Do you currently use any assistive devices (hearing aids, canes, braces, crutches)? Yes ☐ No ☐ Specify ___________________

Have you previously had difficulty with school, studies, teachers, etc.? Yes ☐ No ☐ Specify ____________________________

Have you been treated by any health practitioner/healer in the last 5 years for any condition not mentioned above? Yes ☐ No ☐

Treatment _______________________________________ When ___________________________ Where _____________________________

Do you have a documented learning disability? Yes ☐ No ☐ If yes, please submit documentation (IEP, 504 plan, etc.) to the Director of Student Support Services. Students with documented learning disabilities reserve the right to request special accommodations and/or testing modifications. Arrangements must be made through the Director of Student Support Services.

Tuberculosis Risk Exposure Questionnaire

Part A: Past Diagnosis of Tuberculosis (TB)

1. Have you ever been sick with tuberculosis (TB)? YES ☐ NO ☐
2. Have you ever had a positive (usually a red bump) TB skin test (usually done on your forearm)? YES ☐ NO ☐

What was the date and reaction of your last TB test? ____________________________________

Part B: Tuberculosis Exposure Risk Questionnaire

1. Were you born in a place other than the U.S. or Canada? If yes, where? ______________________________ YES ☐ NO ☐

2. See list of countries on the back of this form. Were you born in or have worked, lived or traveled in any of these countries for more than one month? YES ☐ NO ☐

3. Have you travelled outside of the United States in the last 21 days? YES ☐ NO ☐

4. Have you ever been vaccinated against TB with the BCG vaccine? This vaccination is usually given in the shoulder and frequently leaves a permanent scar.) (Not to be confused with smallpox vaccination given in the U.S. until approximately 1970.) YES ☐ NO ☐

5. Do any of the following conditions or situations apply to you?
   a. Do you have a persistent cough (3 weeks or more), fever, night sweats, fatigue, loss of appetite or weight loss? YES ☐ NO ☐
   b. Have you lived with or been in close contact to a person known or suspected of being sick with TB? YES ☐ NO ☐
   c. Have you ever lived, worked or volunteered on a regular basis in any of the following:
      1. Homeless Shelter/Hospital? YES ☐ NO ☐
      2. Prison / Jail? YES ☐ NO ☐
      3. Drug Rehabilitation Unit? YES ☐ NO ☐

6. Do you use or have you used:
   a. Medications for cancer or transplant rejection? YES ☐ NO ☐
   b. Oral Prednisone or other oral steroids? YES ☐ NO ☐
   c. Illicit drugs (intravenous or crack cocaine)? YES ☐ NO ☐

7. Have you had HIV infection or AIDS, diabetes, leukemia, lymphoma, Hodgkin's disease, or a chronic medical problem? YES ☐ NO ☐
   If yes, please specify. ____

8. Are you pregnant? YES ☐ NO ☐

Student's Signature: ____

Student's Name (print)____Date________________________

Part C: PPD (if required): *If all answers above were "NO" no PPD is required. Skip part C; If any answers above were "YES" PPD is required.*

1. ***PPD*** – Must be done in the U.S. or Canada and within one calendar year prior to admittance, *even if BCG was given*.

Date Placed: ________________________________ Date Read: __________________________________

MM Induration: _____________________________ Result: _____________________________________

2. Chest x-ray (performed in the U.S. or Canada) required if PPD is 10mm or more.

Date of chest x-ray: ____________________Result: ____

3. Treatment plan must be attached.

Health Care Provider's Name *(Signature):* ____ **Date:** ______________________

Health Care Provider's Name *(Print):* ____

Health Care Provider's Address: ____ **Telephone**__________________________

____

Afghanistan
Albania
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bahrain
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia
Bosnia-Herzegovina
Botswana
Brazil
British Virgin Islands
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cambodia
Cameroon
Cape Verde
Central African Republic
Chad
Chile
China
China, Hong Kong SAR
China, Macao SAR
Columbia
Comoros
Congo
Congo, Dem. Republic of
Costa Rica
Croatia
Djibouti
Dominica
Dominican Republic
Ecuador
Egypt
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
Fiji
French Polynesia
Gabon
Gambia
Georgia
Ghana
Guam
Guatemala
Guinea
Guinea-Bassau
Guyana
Haiti
Honduras
Hungary
India
Indonesia
Iran
Iraq
Ivory Coast
Japan
Kazakhstan
Kenya
Kiribati
Korea (North and South)
Kuwait
Kyrgyzstan
Laos
Latvia
Lesotho
Liberia
Libyan Arab Jamahiriya
Lithuania
Macedonia
Madagascar
Malawi
Malaysia
Maldives
Mali
Mauritania
Mexico
Micronesia
Moldova, Republic of
Mongolia
Montenegro
Montserrat
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
New Caledonia
Nicaragua
Niger
Nigeria
Niue
North Mariana Islands
Oman
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Quatar
Romania
Russian Federation
Rwanda
Saint Vincent & Grenadines
Samoa
Saudi Arabia
Senegal
Serbia
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
Spain
Sri Lanka
Sudan
Suriname
Swaziland
Syrian Arab Republic
Taiwan
Tajikistan
Tanzania
Thailand
Timor-Leste
Togo
Tokelau
Tonga
Trinidad and Tobago
Tunisia
Turkey
Turkmenistan
Turks and Caicos Islands
Tuvalu
Uganda
Ukraine
Uruguay
Uzbekistan
Vanuatu
Venezuela
Vietnam
Wallis and Futuna Islands
Yemen
Zambia
Zimbabwe

Tuburculosis (TB) is prevalent in these countries.

Meningococcal Vaccination Response Letter

Dear Parent / Guardian:

As Director of Health Services at Davis College, I am writing to inform you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis. New York State Public Health Law (NYS PHL) §2167 requires institutions, including colleges and universities, to distribute information about meningococcal disease and vaccine to all students meeting enrollment criteria, whether they live on or off campus. Davis is required to maintain a record of the following for each student:

- A response to receipt of meningococcal disease and vaccine information signed by the student or student's parent or guardian
  AND EITHER
- A record of meningococcal immunization within the past 5 years; OR
- An acknowledgement of meningococcal disease risks and refusal of meningococcal immunization signed by the student or student's parent or guardian.

Meningococcal disease is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. Meningococcal disease can cause serious illnesses such as infection of the lining of the brain and spinal column (meningitis) or blood infections (sepsis). The disease strikes quickly and can lead to severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even lead to death.
Meningococcal disease can be easily spread from person-to-person by coughing, sharing beverages or eating utensils, kissing, or spending time in close contact with someone who is sick or who carries the bacteria. People can spread the bacteria that causes meningococcal disease even before they know they are sick. There have been several outbreaks of meningococcal disease at college campuses across the United States.
The single best way to prevent meningococcal disease is to be vaccinated. The meningococcal ACWY (MenACWY) vaccine protects against four major strains of bacteria which cause about two-thirds of meningococcal disease in the United States (U.S.). The MenACWY vaccine is recommended for all U.S. teenagers and young adults up to age 21 years. Protection from the MenACWY vaccine is estimated to last about 3 to 5 years, so young adults who received the MenACWY vaccine before their 16th birthday should get a booster dose before entering college. The meningococcal B (MenB) vaccine protects against a fifth type of meningococcal disease, which accounts for about one-third of cases in the U.S. Young adults aged 16 through 23 years may choose to receive the MenB vaccine series. They should discuss the MenB vaccine with a healthcare provider.
All private insurance plans not grandfathered under the Affordable Care Act are required to cover the cost of MenACWY and MenB vaccines. Contact your health insurance plan to determine whether it covers MenACWY and MenB vaccines. The federal Vaccines for Children (VFC) and NYS Vaccines for Adults (VFA) programs will cover both MenACWY and MenB vaccines for children and adults who have no health insurance or whose health insurance does not cover these vaccines, as well as for children less than 19 years of age who are American Indian or Alaska Native or eligible for Medicaid or Child Health Plus.
This vaccine is not available through Health Services at Davis College. Those who have not been immunized against meningitis should contact their personal physician or County Health Department for availability of the vaccine & any possible immunization clinics. This vaccine may be expensive and may not be covered by all insurance carriers.
Please review the attached Meningococcal Disease Fact Sheet very carefully. It is also available on the New York State Department of Health website at www.health.ny.gov/publications/2168.pdf.
Please complete this Meningococcal Response Form and return it to Health Services with all other health forms.
***** PER PUBLIC HEALTH LAW, NO INSTITUTION SHOULD PERMIT ANY STUDENT TO ATTEND THE INSTITUTION IN EXCESS OF 30 DAYS WITHOUT COMPLYING WITH THIS LAW. THE 30 DAY PERIOD MAY BE EXTENDED IF A STUDENT CAN SHOW AN APPOINTMENT DATE TO HAVE THE VACCINE.***
To learn more about meningococcal disease and the vaccine, please feel free to contact me or consult your child's physician. More information is also available at the Centers for Disease Control and Prevention website at www.cdc.gov/meningococcal/.

Sincerely,

Joanna Johnson

Mrs. Joanna Johnson, BS, RN
Director of Health Services
Davis College
400 Riverside Drive
Johnson City, NY 13790
health@davisny.edu
607-729-1581 ext. 337
Fax: 607-584-7656

Attached you will find the Meningococcal Response Form and the New York State Department of Health Meningococcal Disease Fact Sheet.

MENINGOCOCCAL VACCINATION RESPONSE FORM

New York State Public Health Law requires that all college and university students enrolled for at least six (6) semester hours or the equivalent per semester, or at least four (4) semester hours per quarter, complete and return the following form to Health Services.

Check one box and sign below.

I have (for students under the age of 18: My child has):

□ had meningococcal immunization within the past 5 years. The vaccine record is attached or shown on my official immunization record as provided by my health care provider.

Note: The Advisory Committee on Immunization Practices recommends that all first-year college students up to age 21 years should have at least 1 dose of Meningococcal ACWY vaccine not more than 5 years before enrollment, preferably on or after their 16th birthday, and that young adults aged 16 through 23 years may choose to receive the Meningococcal B vaccine series. College and university students should discuss the Meningococcal vaccine

□ read, or have had explained to me, the information regarding meningococcal disease. I (my child) will obtain immunization against meningococcal disease **within the next 30 days** from my private health care provider, county health department or other immunization clinic.

□ 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.

Signature: ______________________________ Date: ____________________
(Parent/Guardian must sign if student is under 18 years of age)

Print Student's name ______________________________ Student DOB ____/____/____

Student Email ______________________________ Student ID# ____________________

Student Mailing Address ______________________________

____

Student Phone number ( ) ______________________________

Please note: this vaccine is NOT available through our campus Health Services. Check with your health care provider or county Health Department for availability of the vaccine and immunization clinics. This vaccine is expensive and may not be covered by your insurance carrier.

***According to Public Health Law, no institution shall permit any student to attend the institution in excess of 30 days without having this form on file.**

Immunizations

Immunization information must be completed and signed by your health-care provider. All information must be in English, with the name and credentials of the translator if not originally in English.

Last Name ____________________________ First Name ______________________________ Date of Birth __________________
Address ____ City/State/ZIP ___________________________________
Email ____ Cell ___________________________ Home ___________________

A. M.M.R. – Documentation of two doses of MMR are REQUIRED by New York State unless proof of immunity is established by physician-certified disease or serological blood tests.

Dose 1 (after first birthday) #1 ____/_____/_____
Dose 2 (after 15 months old)#2 ____/_____/_____

☐ History of disease (not acceptable for rubella): Measles ____/____/____ Mumps ____/_____/____
Attach a verification statement from the diagnosing physician, nurse practitioner, or physician assistant.

☐ Serological testing establishing immunity: **Results must be attached**

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

- Students born before January 1, 1957
- Medical Contraindications: A written, signed, and dated statement from a physician state if the exemption is temporary or permanent, citing the medical condition that contraindicates immunization. If temporary, the duration of the exemption must be given with an appointment date to have the vaccine.
- Religious exemption: A statement written, signed, and dated by the student (or parent/guardian if the student is a minor) describing his/her genuine and sincere objection to immunization based on religious tenants or practices. Philosophical objections are not acceptable.

B. Meningitis - Required by New York State. Completion of Meningitis Response Form required by student or parent if student is underage.

☐ Menactra (conjugated vaccine) Date: ____/______
☐ Menomune (Quadrivalent Polyzaccharide vaccine) Date(s): ______/______ _____/_______

C. TETANUS-DIPHTHERIA

1. Primary series with DTaP or DTP: Primary series completed ___/____/____
2. Tetanus-Diphtheria (Td) booster within last 10 years: ____/____/____
3. Tdap ___/____ (ex Adacel)

Record of Other Immunizations/Test Results

C. POLIO Primary series completed ____/____ (IPV/OPV)

D. Hepatitis B
1. Dose #1 ____/_____ Dose #2 ____/____ Dose #3 ____/____
2. Hepatitis B surface antibody: Date ___/____ Result: Reactive ☐ Non-reactive ☐

E. Hepatitis A Dose #1 ____/_____ Dose #2 ____/____

F. Varicella Verification of disease or vaccine Illness date ___________ Vaccine Date __________

G. Gardasil (HPV) Dose #1 ____/_____ Dose #2 ____/____ Dose #3 ____/____

I certify that the information in part 2B and the immunization section is accurate: HEALTH CARE PROVIDER SIGNATURE REQUIRED

An official record must be attached OR your medical provider must sign this form.

Health Provider Signature ____

Health Provider Name (Printed) ____

Office Address ____

____

Phone # ____

Authorization for Treatment and Medical Consent

FOR STUDENTS UNDER EIGHTEEN ONLY

TO: Parents and Guardians of students under 18 years of age

Students attending college are generally considered independent adults and parental consents for medical care for those under 18 years of age are not routinely required. However, there are occasional situations in which a parental signature is desirable for treatment. Vaccinations and minor surgical procedures are two examples of such situations.

To avoid delay in such treatment interventions, you are encouraged to sign the authorization below for medical or emergency treatment. Please return the form to Health Services. Should the student seek or be referred for care at an off-campus facility, the policies and procedures of that facility will be followed.

Parents and guardians are reminded that the college Health Services only provides First Aid, care for general sickness, advice on health issues & ordinary over the counter medicines. When deemed advisable, referrals are made to local clinics and physicians. Davis College students have two excellent hospitals within two miles of the campus for emergencies.

It is the policy of the college Health Services Department that ALL student medical records are confidential. No information is released without written authorization of the student (or parent/guardian if student is under 18 years of age) except in certain emergencies or public health situations or under a court-ordered subpoena.

CONSENT OF PARENT OR GUARDIAN FOR MEDICAL OR EMERGENCY TREATMENT

I, ____, pursuant to the authority vested in me

(Name of parent/guardian)

as: parent / guardian of _________________________________, do hereby authorize

(Name of student)

Health Services of Davis College to give treatment or refer my__________________________________

(son or daughter)

for appropriate medical treatment. This does not include the right to perform surgical procedures without my further consent, except in the case of emergency & when after all effort has been made to locate me, I am found unavailable.

Student's Date of Birth__________________________ Social Security Number_______________________

Numbers where I can be reached: (   ) _______________________   (   )________________________

Evenings: (   )___________________ Email: ____

Signature: ____ Date: __________________________

Davis College, 400 Riverside Dr., Johnson City, NY 13790, health@davisny.edu, 607-729-1581 ext.337, Fax: 607-584-7656

Health Insurance Verification

Last Name ___________________________ First Name ______________________ MI ______ DOB _________

Home Address (Street/P.O. Box) ___________________________________ Email ____________________________

City/State/Zip _______________________________________ Cell _________________ Home _________________

Davis College requires all students taking 6 credits or more, on campus, and/or all students participating in athletic programs through the college to show proof of health insurance covering them in Broome County, New York. This requirement serves as a 'safety net' against unforeseen medical expenses which to pay could interrupt or cancel the academic goals of the student.

Davis College does not offer a student health insurance plan.

- International Students must show proof of health insurance coverage and should investigate what is available through their country's Travel Abroad Insurance companies. Premiums for such policies must be paid in full for one full year and be renewed annually for as long as the student is enrolled at Davis College.
- An individual who does not have insurance coverage is not eligible for any hospital patient assistance program.
- **All athletic injuries fall under the student's own health insurance plan. There is no additional coverage by the college.**

☐ I do not need to show proof of Health Insurance coverage because I am currently taking less than 6 credits and will not be participating in campus athletics.

Verification:

☐ Attached is a copy of my current/valid health insurance card (front and back), which provides coverage for me in Broome County, New York. I understand that any medical treatment not covered by my health insurance provider will be billed to me and will be my own personal financial responsibility.

☐ I opt out of enrolling in any health insurance plan. As of this writing (7/5/17), I understand the government imposes financial consequences for not having insurance coverage and that any medical bills incurred by me are also my own financial responsibility. **Athletes and International Students MAY NOT choose this option.**

Signature: ____ Date: __________________________

Parent/Guardian must sign if student is under 18 years of age