



Name: \_\_\_\_\_

**DISABILITY:** If you consider yourself handicapped or disabled in any way please complete the following with specific information

- Emotional     Neurological     Hearing     Pulmonary     Learning     Mobility     Other \_\_\_\_\_
- None of the above    Explain: \_\_\_\_\_

I authorize Health Services to share information regarding my disability with the Coordinator for Students with Disabilities.     YES     NO

\_\_\_\_\_  
Signature (Student or Parent/Guardian if student is a minor.)

\_\_\_\_\_  
Date

**LIST ALL MEDICATIONS CURRENTLY BEING TAKEN WITH DOSAGE, FREQUENCY AND CONDITION FOR WHICH IT IS BEING TAKEN:**

MEDICATIONS	DOSAGE	FREQUENCY	CONDITION

**DO YOU HAVE ALLERGIES TO ANY OF THE FOLLOWING? IF SO, DESCRIBE REACTIONS;**

- None known**
- Anesthesia \_\_\_\_\_
- Environmental (pollen, dust, etc.) \_\_\_\_\_
- Foods (please list) \_\_\_\_\_
- Immunizations \_\_\_\_\_
- Insect stings \_\_\_\_\_
- Latex \_\_\_\_\_
- Medications/antibiotics (please list) \_\_\_\_\_
- Other (please list) \_\_\_\_\_

**PLEASE LIST ALL MEDICAL PROBLEMS AND TREATMENTS INCLUDING DATES:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PLEASE LIST ALL PAST ACCIDENTS, OVERNIGHT HOSPITALIZATIONS AND SURGERIES (Please indicate dates.)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had to interrupt school or work for physical, emotional or mental illness?     YES     NO

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

**FAMILY MEDICAL HISTORY**

If any of your immediate family had/have the following, check the box indicating which family member it applies to:

	Father	Mother	Sibling	Grandparent		Father	Mother	Sibling	Grandparent
Alcohol Abuse					Heart Disease				
Drug Abuse					Died of heart disease under age 50				
Cancer					High Blood Pressure				
Diabetes					Stroke				
Elevated Cholesterol					Emotional/Mental Illness				
					Other				

Family Member	Age	State of Health	Occupation (parents only)	Family Member	Age	State of Health
<b>Father</b>				<b>Brother</b>		
<b>Mother</b>				<b>Sister</b>		
<b>Brother</b>				<b>Sister</b>		
<b>Brother</b>				<b>Sister</b>		

=

**Release of Information**  
(Required)

**Please check appropriate box (es) and sign below:**

I hereby authorize release of information contained in my Health Assessment, Sports Physical exam and/or Immunization Record to:

- The Skidmore College SCOOP Program and/or their representative (s) to comply with requirements for attendance.
- College athletic trainers and/or consulting physician (s).
- Skidmore College Campus Safety during an urgent situation. (Allows Campus Safety to access limited medical information in the event of an emergency.)

**This is a specific authorization and may not be extended for any other purpose.**

**PRINT STUDENT NAME:** \_\_\_\_\_

\_\_\_\_\_  
STUDENT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PARENT OR LEGAL GUARDIAN

\_\_\_\_\_  
DATE

If student is under 18 years of age.

\_\_\_\_\_  
RELATIONSHIP TO STUDENT



Name: \_\_\_\_\_

**PHYSICAL EXAMINATION : (Required within 12 months of arrival on campus.)**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_

	NL	ABNL	COMMENTS
SKIN	___	___	_____
LYMPH	___	___	_____
EYES	___	___	_____
EARS	___	___	_____
NOSE	___	___	_____
MOUTH/THROAT	___	___	_____
NECK/THYROID	___	___	_____
BREASTS	___	___	_____
LUNGS	___	___	_____
HEART	___	___	_____
ABDOMEN	___	___	_____
BACK/SPINE	___	___	_____
GENITALIA	___	___	_____
EXTREMITIES	___	___	_____
NEUROLOGICAL	___	___	_____
OTHER	___	___	_____

Is this person physically capable of attending an Outdoor Orientation Program without restriction; including canoeing, mountain climbing and hiking?

YES  NO

Does this student have any injuries, disabilities, or congenital abnormalities?

YES  NO

EXPLAIN: \_\_\_\_\_  
\_\_\_\_\_

Special Accommodations Needed:  YES  NO

EXPLAIN: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PROVIDER INFORMATION:**

I have performed a physical examination on this patient AFTER 09/01/06. All medical/psychiatric conditions and therapies are noted above or on attached pages.

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

Print Provider Name: \_\_\_\_\_

Address (Please print or stamp):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_ Fax # (\_\_\_\_) \_\_\_\_\_

Signature of Health Care Provider \_\_\_\_\_ Degree \_\_\_\_\_

**Saratoga Springs, NY 12866**

**Phone: (518) 580-5550**

**Fax: (518) 580-5556**

**IMMUNIZATION RECORD:**

Required by New York State Law and Skidmore College.

**NAME:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**REQUIRED:**

**A. MMR (Measles, Mumps, Rubella):**

1. **TWO DOSES** of MMR. Dose #1 must be given within 4 days of first birthday or later and dose #2 at least 28 days after dose #1.

MMR #1  \_\_\_\_\_ MMR #2  \_\_\_\_\_  
 Mo Day Yr Mo Day Yr

**OR**

2. Date of Measles Immune titer \_\_\_\_\_ Results: (Attach lab report.)  
 Mo Day Yr

Date of Mumps immune titer \_\_\_\_\_ Results: (Attach lab report.)  
 Mo Day Yr

Date of Rubella immune titer \_\_\_\_\_ Results: (Attach lab report.)  
 Mo Day Yr

**OR**

3. Date provider diagnosed Measles disease: \_\_\_\_\_  
 Mo Day Yr

Date provider diagnosed Mumps disease \_\_\_\_\_  
 Mo Day Yr

Physician/provider diagnosis of Rubella disease is **NOT** acceptable.

**B. TETANUS-DIPHTHERIA-PERTUSSIS:**

Most recent vaccine/ booster (Required within past 10 years.):

TD \_\_\_\_\_ **OR** TDaP \_\_\_\_\_  
 Mo Day Yr Mo Day Yr

**C. POLIO:**

1. Completed primary polio vaccine series: \_\_\_\_\_  
 Mo Day Yr

2. Most recent polio booster: \_\_\_\_\_  
 Mo Day Yr

**RECOMMENDED:**

**D. BACTERIAL MENINGITIS VACCINATION:**

Menomune (polysaccharide) \_\_\_\_\_  
 Mo Day Yr

Menactra (conjugate) \_\_\_\_\_  
 Mo Day Yr

**E. HEPATITIS A:** #1 \_\_\_\_\_ #2 \_\_\_\_\_  
 Mo Day Yr Mo Day Yr

**F. HEPATITIS B:**  
 #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_  
 Mo Day Yr Mo Day Yr Mo Day Yr

**G. HEPATITIS A & B combined vaccine: (Twinrix)**

#1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_  
 Mo Day Yr Mo Day Yr Mo Day Yr

**H. HPV (Humanpapilloma Virus vaccine):**

Gardasil:  
 #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_  
 Mo Day Yr Mo Day Yr Mo Day Yr

Other (Specify) \_\_\_\_\_  
 #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

**I. VARICELLA (chickenpox) VACCINE:**

#1 \_\_\_\_\_ #2 \_\_\_\_\_  
 Mo Day Yr Mo Day Yr

History of VARICELLA disease:  Yes  No

**J. Other Immunizations (please list):**

1 \_\_\_\_\_ Date \_\_\_\_\_  
 Mo Day Yr  
 2 \_\_\_\_\_ Date \_\_\_\_\_  
 Mo Day Yr

**PROVIDER INFORMATION REQUIRED:**

\_\_\_\_\_  
 Name of Health Care Provider (please print) Degree

\_\_\_\_\_  
 Signature of Provider

\_\_\_\_\_  
 Address (please print or stamp):

\_\_\_\_\_  
 Phone #: (\_\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_  
 Fax#: (\_\_\_\_\_) \_\_\_\_\_

**For Administrative Purposes Only:**

**Form Complete:** \_\_\_ Yes \_\_\_ No **Date:** \_\_\_\_\_

**Reviewer:** \_\_\_\_\_

**Action Needed:** \_\_\_\_\_

**Date requested information received:** \_\_\_\_\_ **Reviewer:** \_\_\_\_\_

Health Services  
 815 North Broadway  
 Saratoga Springs, NY 12866  
 Phone: (518) 580-5550 Fax: (518) 580-5556

## TUBERCULOSIS SCREENING

NAME (Please Print): \_\_\_\_\_ DOB: \_\_\_\_\_

**A. Screening Questionnaire**  
*Required for All Students*

1) Does the student have signs or symptoms of active TB?  
 Yes  No  
 If *no*, proceed to question 2.  
 If *yes*, proceed to **Part B. Tuberculosis Testing**.

2) Is the student a member of a high-risk\* group?  
 Yes  No  
*\*Categories of high risk students include those who have arrived within the past 5 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 testing only 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 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 15mg/d for 1 month) or other immunosuppressive disorders.*

**If student is asymptomatic and/or is not at high risk, then STOP.** No further evaluation is needed at this time.

**If student is symptomatic and/or at high risk, then proceed to Part B.**

**B. Tuberculosis Testing**  
*Required ONLY if answers to Questions 1 and/or 2 of Section A were "Yes"*

**Please note:** A history of BCG vaccination should not preclude testing of a member of a high risk group.

If there is a history of a past positive TB test, proceed to question 4.

3) **Tuberculin Skin Test** (PPD or Mantoux only – Required within 12 months of arrival on campus if indicated by questions 1 and/or 2):

**Date Placed:** \_\_\_/\_\_\_/\_\_\_ **Date Read:** \_\_\_/\_\_\_/\_\_\_  
 Mo Day Yr Mo Day Yr

**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 within 12 months of arrival on campus if TB skin test is positive):

**Date of x-ray:** \_\_\_/\_\_\_/\_\_\_  
 Mo Day Yr  
**Result:**  Normal  Abnormal

5) **Preventive or Therapeutic Tuberculosis Treatment : Medication(s)** (Please list):

\_\_\_\_\_ Dates Taken: \_\_\_\_\_  
 \_\_\_\_\_ Dates Taken: \_\_\_\_\_  
 \_\_\_\_\_ Dates Taken: \_\_\_\_\_

**PROVIDER INFORMATION REQUIRED:**

\_\_\_\_\_  
 Name of Health Care Provider (Please print.)

\_\_\_\_\_  
 Degree

\_\_\_\_\_  
 Signature of Provider

Address: (Please print or stamp.)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Phone #: ( ) \_\_\_\_\_  
 Fax #: ( ) \_\_\_\_\_

**ADMINISTRATIVE PURPOSES ONLY**

Form Complete: \_\_\_ Yes \_\_\_ No Action Needed: \_\_\_\_\_ Date Reviewed: \_\_\_\_\_  
 Reviewer: \_\_\_\_\_ Date of Contact: \_\_\_\_\_ Date Requested Info Received: \_\_\_\_\_ Reviewer: \_\_\_\_\_