

**SKIDMORE COLLEGE
SUMMER PROGRAM HEALTH FORM**

**815 North Broadway
Saratoga Springs, NY 12866-1632**

SUMMER PROGRAM'S NURSE USE ONLY

Program: _____

- Emergency Contact Complete
- Signed by Health Care Provider
- Immunization Record Complete

Required for all participants under 18 years of age, or on campus for 30 days or more.

HEALTH ASSESSMENT - SUMMER PROGRAMS

INSTRUCTIONS AND INFORMATION - IMPORTANT PLEASE READ!

1. This form must be returned to your summer program director prior to arrival at the college. **Immunizations *are required* for enrollment. Participants will be seen at Skidmore College Health Services only if a completed form is on file.**
2. Page 1 should be filled out **prior** to going to your health care provider.
3. Page 2 should be completed by your non-parental health care provider.

PLEASE TYPE OR PRINT

Name of Summer Program: _____

Name _____ Home Phone #: -- --

Last First MI

Home Address _____

#/Street City State Zip Code Country

Gender: male female Date of Birth: SS#

Father's Name: _____ Mother's Name: _____

Address: _____ Address: _____

Phone: (H) _____ (W) _____ Phone: (H) _____ (W) _____

Cell Phone: _____ Cell Phone: _____

Email Address: _____ Email Address: _____

PRIMARY PERSON TO CONTACT FOR CONSENT FOR TREATMENT OR IN CASE OF EMERGENCY

Name: _____ **Check one:** Parent Legal Guardian Spouse Other _____

Address: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____ Email Address: _____

INSURANCE INFORMATION:

Insurance Co. _____ Insured's Name _____

Address: _____ Telephone _____

Insured's SS# _____ Policy # _____ Group# _____

CONSENT FOR EVALUATION/EXAMINATION OF PARTICIPANTS UNDER 18 YEARS OF AGE :

I hereby grant permission to Skidmore College Health Services staff for evaluation and examination of my child/ward in the event of medical illness or injury.

Prior to prescribing treatment or referring your child/ward to an outside medical provider, Health Services will make every attempt to contact a parent or guardian.

SIGNATURE OF PARTICIPANT OR PARENTAL/LEGAL GUARDIAN

DATE

MENINGITIS VACCINATION RESPONSE (REQUIRED BY NEW YORK STATE LAW):

- I have had or my son/daughter has had the bacterial meningitis vaccine.
- I have read, or have had explained to me, the information regarding bacterial meningitis disease. I understand the risk of not vaccinating myself/son/daughter and have decided to decline vaccination at this time.

SIGNATURE OF PARTICIPANT OR PARENT/LEGAL GUARDIAN

DATE

RELATIONSHIP TO PATIENT

() _____
PHONE NUMBER

Required

REQUIRED BY NEW YORK STATE LAW: *Serologic evidence of immunity to measles, mumps and rubella is acceptable only when copies of laboratory reports are attached.*

A. MEASLES (Rubeola) –Must have 2 Measles or MMR injections, both AFTER FIRST BIRTHDAY AND AT LEAST 30 DAYS APART, if you were born after 1957.

Primary Measles or MMR immunization #1 ____/____/____
Mo. Day Yr.
2 measles required #2 ____/____/____
Mo. Day Yr.

B. MUMPS ____/____/____
Mo. Day Yr.

C. RUBELLA ____/____/____
Mo. Day Yr.

D. TETANUS-DIPHTHERIA
Latest booster: ____/____/____
Mo. Day Yr.

E. POLIO Completed primary series of Polio immunizations: ____/____/____
Mo. Day Yr.

F. TB SCREENING
1. Does the participant have signs or symptoms of active TB? YES NO
If no, proceed to question 2.

If yes, proceed with additional evaluation to exclude active TB disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.

2. Is the participant a member of a high-risk group¹? YES NO
If no, stop. No further evaluation is needed at this time.

If yes, place tuberculin skin test (Mantoux only). 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 PPD, proceed to question 4.

3. Tuberculin Skin Test (required within 1 year of Summer Program **if needed after above screening**).
Date given: ____/____/____ 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 6 months of Summer Program **if tuberculin skin test is positive**).
Result: Normal Abnormal Date of x-ray ____/____/____
Mo Day Yr

¹Categories of high-risk students include those students 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 screening if they have arrived from countries EXCEPT those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia, 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 jejunioleal by-pass, chronic

malabsorption syndromes, prolonged corticosteroid therapy (e.g. Prednisone 15 mg/d for 1 month) or other immunosuppressive disorders.

Recommended Immunizations

G. MENINGITIS ____/____/____
Mo. Day Yr

H. VARICELLA Vaccination (recommended if no history of chickenpox: ____/____/____
Mo. Day Yr.

History of chickenpox: Yes No

I. HEPATITIS B ____/____/____ ____/____/____ ____/____/____
Mo Day Yr Mo Day Yr Mo Day Yr

J. HIB Completed primary series of HIB immunization: ____/____/____
Mo Day Yr

Required Medical History - to be completed by health care provider

Allergies Yes No

If yes, please list _____

List all current medications: _____

List all current medical problems and related treatments: _____

Disability : If the participant is handicapped or disabled in any way please complete the following :

Emotional Neurological Pulmonary Learning Locomotion
 None Other _____

Special Accommodations Needed: NO YES

EXPLAIN: _____

I have performed a physical examination on this patient within the past year. All medical/psychiatric conditions and therapies are noted above or on attached pages. She/he may participate in the above program without restrictions.

Exceptions (if any): _____

Date of Exam: ____/____/____
Mo Day Yr

Signature _____ **Degree:** _____

Print Name: _____

Address : _____

Telephone: () _____ **Fax:** () _____