

SKIDMORE COLLEGE
SUMMER STAFF HEALTH FORM
 815 North Broadway
 Saratoga Springs, NY 12866-1632

SUMMER PROGRAM'S NURSE USE ONLY	
Program:	_____
<input type="checkbox"/>	Emergency Contact Complete
<input type="checkbox"/>	Signed by Health Care Provider
<input type="checkbox"/>	Immunization Record Complete

HEALTH ASSESSMENT - SUMMER PROGRAMS STAFF

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 employment.**
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	Phone:	Cell Phone:
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Last	First	MI
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Home Address					
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#/Street	City	State	Zip Code	Country
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Email Address: _____

Gender: male Date of Birth SS#

female

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

Address: _____ Address: _____

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

PRIMARY PERSON TO CONTACT IN CASE OF EMERGENCY

Name: _____

Check one: Parent Legal Guardian Spouse Other _____

Address: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____ Beeper: _____

INSURANCE INFORMATION:

Insurance Co. _____ Insured's Name _____

Address: _____ Telephone _____

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

DISABILITY: If you are handicapped or disabled in any way please complete the following and attach specific information

Emotional Neurological Hearing Pulmonary Learning Locomotion None Other _____

Name: _____

Date of Birth: _____

TO BE COMPLETED BY YOUR HEALTH CARE PROVIDER: *Please indicate none when applicable.*

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

MEDICATIONS	DOSAGE	FREQUENCY	CONDITION
<input type="checkbox"/> None			

PLEASE LIST ALL PAST MEDICAL PROBLEMS AND RELATED TREATMENTS:

None

PLEASE LIST ALL CURRENT MEDICAL CONDITIONS:

None

PLEASE LIST ANY ALLERGIES:

None

REQUIRED BY NEW YORK STATE LAW: *Serologic evidence of immunity is acceptable only when copies of laboratory reports are attached.*

Fill in dates:

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. History of Chickenpox Yes No

G. TB SCREENING

1. Does the patient 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 patient 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 employment **if needed after above screening**).

Date given: ____/____/____ Date read: ____/____/____

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 employment **if tuberculin skin test is positive**).

Result: NL ABN Date: ____/____/____

¹Categories of high-risk patients include those patients 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, patients 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 patients 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 jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. Prednisone 15 mg/d for 1 month) or other immunosuppressive disorders.

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): _____

Special Accommodations Needed: NO YES

EXPLAIN: _____

Date of Exam: ____/____/____

Signature _____ **Degree:** _____

Print Name: _____

Address : _____

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