

Student Health Center
Clarkson University
Box 5643
Potsdam, NY 13699-5643
Tele: 315-268-6633
Fax: 315-268-6448

Dear Student,

Congratulations on your acceptance to Clarkson University. We look forward to your arrival and also to helping you maintain a healthy lifestyle. Your health will play a very important role in your academic success at Clarkson.

In order for us to assist you with your health care, we need your help. The **Student's Primary Care Provider Information** (page 2) and the 3 health forms must be completed and returned to us prior to your arrival. The **Health History Report** consists of pages 3-5 which need to be completed by you before going to your Health Care Provider. **Physical Examination Part I** (page 6) must be done within one year prior to your arrival on campus. All information is kept confidential.

The second form is the **Immunization Report PART II** (page 7). Most students will be able to locate past immunization information by contacting their pediatrician's office, high school health office or current Health Care Provider. Please have your Health Care Provider sign this form to verify its accuracy. If records are unavailable or if there is any doubt as to the type of vaccine, you must be revaccinated.

If you have medical contraindications to vaccines, your Health Care Provider may indicate these and sign the form verifying these contraindications. Exemptions are also given to students with religious beliefs contrary to these medical practices, if supporting documents are also submitted to us. All reports and supporting documents must be in English please.

Part II of the Immunization Report must also be completed and signed, only if you do not have valid vaccination for meningococcal disease. If you are 18 or older, you may sign this yourself. If you are under 18, it must be signed by your parent/guardian. The Meningitis Response Form is a New York State Public Health Law.

Part III (page 8) is the **PPD and Tuberculosis (TB) Screening Form**. This form must be completed by your Health Care Provider.

All health reports are pre-matriculation requirements, and must be filled out completely with signatures and returned to by July 1st for the fall semester and December 1st for the spring semester. Late fees will be charged to students with incomplete forms and to those who do not submit forms.

Sincerely,

Susan Knowles MSN FNP-BC
Director of Student Health Center
Clarkson University

Name: _____ Social Security #: _____

Student's Primary Care Provider Information

At times it is important for the providers to contact the student's primary care providers to discuss their care. Please provide the information below, if available.

Name of Provider: _____ Phone #: _____

Address _____ Fax #: _____

Student's Health Insurance Information

Primary Insurance: _____

Subscriber's Name: _____ Social Security # _____

Subscriber's DOB: _____ Subscriber's relationship to student: _____

Insurance ID # _____ Insurance Group #: _____

PLEASE ATTACH A COPY OF YOUR INSURANCE AND PRESCRIPTION CARD

Emergency Contact Information

Student's cell phone#: _____ Student's email: _____

Emergency Contact #1: _____ Relationship to student: _____

Address: _____

Home phone # _____ cell # _____ work # _____

Emergency Contact #2: _____ Relationship to student: _____

Address: _____

Home phone # _____ cell # _____ work # _____

If you can not supply the Health Center with your insurance information at the time of your visit, it will be your responsibility to provide the hospital or lab with this information or you will be billed as self-pay.

CLARKSON UNIVERSITY
Health History Report

Please Print

Name _____ female male SS# _____

Date of Birth _____ Home Address _____

Telephone _____ Student # _____ Undergrad Student
Grad Student

<u>Do you , or have you:</u>	YES	NO
1) require use of a wheelchair?	0	0
2) require special housing due to health conditions ?	0	0
3) been refused employment for health reasons ?	0	0
4) been restricted in your work for health reasons ?	0	0
5) require a special diet?	0	0
6) been refused for or discharged from military service for health reasons?	0	0
7) had loss of function of any body organ?	0	0
8) object to medical treatment?	0	0
9) object to blood transfusions in a life threatening situation?	0	0
10) receive allergy injections?	0	0

Please explain in detail the circumstances for any yes answer to the above questions.

11) Do you have any allergies to medications, food, serums, hay fever, other? _____
If yes, please list: _____

12) Have you ever been hospitalized? _____ If so, what for and when? _____

13) Have you had any surgery? _____ If so, what for and when? _____

14) Do you regularly use prescription medications? _____ Please list – prescribed by
your medical provider. _____

15) Do you take any over the counter medications or supplements (aspirin, laxative, or
vitamins) _____

16) Do you have medical disabilities? _____ If so, please list them _____

17) Do you have a learning disability? _____

18) Have you had any serious illness or injuries? _____ if so, please list them with dates, i.e. fractures, hepatitis, _____

Mark any problems you have or have had that have been diagnosed or treated by a physician or other health care professional.

- | | | | | | |
|-----------------------------------|-----|----|---------------------------|-----|----|
| 19) Alcoholism or alcohol abuse | Yes | No | 41) Hypoglycemia | Yes | No |
| 20) Anemia or other blood disease | Yes | No | 42) Kidney problems | Yes | No |
| 21) Anorexia | Yes | No | 43) Knee problems | Yes | No |
| 22) Asthma | Yes | No | 44) Mental Health issues* | Yes | No |
| 23) Back problems of any type | Yes | No | 45) Migraine headaches | Yes | No |
| 24) Bladder infection-more than 1 | Yes | No | 46) Mono | Yes | No |
| 25) Bleeding disorders | Yes | No | 47) Nervous stomach | Yes | No |
| 26) Bronchitis-chronic | Yes | No | 48) Nervous disorder | Yes | No |
| 27) Bulimia | Yes | No | 49) Obesity | Yes | No |
| 28) Cancer | Yes | No | 50) Phlebitis | Yes | No |
| 29) Chicken pox | Yes | No | 51) Pneumonia | Yes | No |
| 30) Colitis | Yes | No | 52) Rheumatic fever | Yes | No |
| 31) Depression | Yes | No | 53) STDs | Yes | No |
| 32) Diabetes | Yes | No | 54) Sinus trouble-chronic | Yes | No |
| 33) Drug abuse or addiction | Yes | No | 55) Skin diseases/rashes | Yes | No |
| 34) Epilepsy or convulsions | Yes | No | 56) Stomach or intestinal | Yes | No |
| 35) Ear diseases or problems | Yes | No | 57) Suicide attempt | Yes | No |
| 36) Eye diseases or problems | Yes | No | 58) Thyroid problems | Yes | No |
| 37) Hearing loss | Yes | No | 59) Tension headaches | Yes | No |
| 38) Heart problem | Yes | No | 60) Tuberculosis | Yes | No |
| 39) Hepatitis/liver problems | Yes | No | | | |
| 40) High blood pressure | Yes | No | | | |

***Please include ADD/ADHD, Generalized Anxiety Disorder.**

Men only (question #61 only)

61) Any problems with prostate gland, testicles or penis Yes No

Women only (questions 62-68)

- | | | | | | |
|---|-----|----|---|-----|----|
| 62) Menstrual problems-irregular periods, severe cramps | | | | Yes | No |
| 63) Pelvic infections | Yes | No | 66) Abnormal pap test | Yes | No |
| 64) Ovarian cysts | Yes | No | 67) Fibrocystic or other breast disease | Yes | No |
| 65) Abnormal pap test | Yes | No | 68) Frequent vaginal infections | Yes | No |

Have you ever.....

- 1) Smoked tobacco? Yes No
- a) Do you now? Yes No
- b) How many years have you smoked? _____
- c) How many packs do/did you smoke per day? _____
- 2) Use alcohol? Yes No
- a) Do you now? Yes No
- b) How much do/did you drink per week? _____
- 3) Used street drugs: Yes No
- a) Do you now? Yes No
- b) Drugs used _____
- 4) Been exposed to occupational hazards, i.e. chemical radiation? Yes No

Family History.... Has anyone in your family, living or dead, had: (family means blood relatives, i.e. parents, grandparents, siblings, children).

- | | | | |
|------------------------|--------|-----------------------|--------|
| 1) Diabetes | Yes No | 8) Sickle cell anemia | Yes No |
| 2) Cancer | Yes No | 9) Bleeding trait | Yes No |
| 3) High blood pressure | Yes No | 10) Stroke | Yes No |
| 4) Mental illness | Yes No | 11) Suicide | Yes No |
| 5) Alcoholism | Yes No | 12) Stomach disease | Yes No |
| 6) Tuberculosis | Yes No | 13) Asthma | Yes No |
| 7) Heart trouble | Yes No | 14) Epilepsy | Yes No |

Please give details of any pertinent information which has not been covered by this form, or give positive responses on the information above. _____

I, the undersigned, do hereby certify that the answers to the above questions are true to the best of my knowledge.

Student's Signature

Date

History reviewed by: _____

PHYSICAL EXAMINATION /PART I

Name _____ Date of Birth _____
 Month Day Year

Temperature _____ Pulse _____ Respirations _____ Blood Pressure ____/____

Height _____ft _____inches Weight _____lbs

Vision: Without corrective lenses - Far R _____ L _____

Near R _____ L _____

With corrective lenses - Far R _____ L _____

Near R _____ L _____

Color vision – Normal 0 Abnormal 0

LAB RESULTS: Urinalysis: Glucose _____ Protein _____ Other _____

Results of additional testing (if deemed app.) i.e. pap tests, CBC, EKG, etc.

Mark NORMAL OR ABNORMAL and describe below:

	<u>Normal</u>	<u>Abnormal</u>		<u>Normal</u>	<u>Abnormal</u>
1) general	0	0	5) pulse	0	0
2) skin	0	0	16) abdomen	0	0
3) head	0	0	17) inguinal	0	0
4) eyes	0	0	18) hernia	0	0
5) ears	0	0	19) genitalia	0	0
6) nose	0	0	20) anus	0	0
7) pharynx	0	0	21) spine, back	0	0
8) neck	0	0	22) joints	0	0
9) lymph nodes	0	0	23) upper extrem.	0	0
10) thyroid	0	0	24) lower extrem.	0	0
11) chest	0	0	25) neurological	0	0
12) breasts	0	0	26) reflexes	0	0
13) lungs	0	0	27) other	0	0
14) heart	0	0			

Please comment on positive history and physical findings. _____

I have examined this student and reviewed his/her medical history. He/She is in good physical condition and may participate in unlimited physical activity including intercollegiate sports, intramurals, and ROTC.

REQUIRED INFORMATION

Signed: _____

Print name _____

Address _____

Phone _____

Fax _____

Date of Exam _____

RETURN TO:

Student Health Center

Clarkson University

Box 5643

Potsdam, NY 13699-5643

Tele: 315-268-6633 / Fax: 315-268-6448

Immunization Report/ Part II
Student Health Center Clarkson University, Potsdam, NY 13699-5643
Tele: 315-268-6633 Fax: 315-268-6448

Name _____ Date of Birth _____ Student # _____
Month Day Year

Part I - to be completed and signed by your health care provider

Required Immunizations - Please list as Month/Day/Year

MMR (2 doses required) _____

Td (adult) (must be within 10 years) _____ OR Tdap _____

PPD (SEE PART III TUBERCULOSIS SCREENING)

RECOMMENDED IMMUNIZATIONS-PLEASE LIST AS MONTH/DAY/YEAR

Chicken Pox Vaccine _____ HPV Vaccine _____

HAV/HBV (twinrix) _____

Hepatitis B _____

Menomune _____ OR Menactra _____

Please check if applicable:

_____ Student exempt due to medical contraindication

_____ Student exempt due to religious beliefs-requests for exemption must be in writing.

Health Care Provider Name _____ Signature _____

(Required)

Health Care Provider Telephone #: _____

Part II - only completed and signed by student, or by parent/guardian for student under the age of 18, if the student does not have valid vaccination for meningococcal disease.

Meningitis Information Response Form (NYS PHL #2167)

Check and sign

_____ I have (my child has) read or have had explained to me the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I (my child) will not obtain immunization against meningococcal meningitis disease.

Signed _____ Date _____

Tuberculosis (TB) Screening Form/Part III REQUIRED

Name: _____ Social Security # _____

Step 1 PPD

You are **REQUIRED** to have a tuberculin skin test, even if you've had a Bacille Calmette-Guerin (BCG) immunization.

Date PPD given: _____ (m/d/y) Date PPD read: _____ (m/d/y)

Results: _____ MM of induration Interpretation: Positive Negative

If your PPD test is "Positive" please complete step 2

Health Care Provider's signature: _____ Date: _____

Step 2 PLEASE ANSWERS THESE QUESTIONS. If necessary, complete step 3 to fulfill requirements.

Do any of the following questions apply to you?

Yes No Have you spent more than one month in AFRICA, ASIA (including China and Korea), or LATIN AMERICA in the last 5 years?

Yes No Have you been exposed to someone with TB or someone who has tested positive for TB?

Yes No Do you have a history of a positive PPD test?

Yes No Do you have a poorly functioning immune system (history of HIV infection, taking immune suppressing drugs, currently taking chemotherapy for cancer)?

Yes No Have you had a gastric (stomach) bypassing operation or had part of your stomach removed?

Yes No Are you underweight?

Yes No Have you worked in an institutional setting (hospital, nursing home, homeless shelter, correctional facility, etc..)?

Yes No Have you ever used injection drugs?

Yes No Do you have diabetes, chronic kidney failure, leukemia or lymphoma, or an intestinal malabsorption syndrome (celiac sprue, Whipple's disease, cystic fibrosis, etc..)?

Do you have any of the following symptoms?

Yes No Cough for over 3 weeks

Yes No Night Sweats

Yes No Decreased appetite

Yes No Unexplained weight loss

Yes No Unexplained fever (temperature over 38°C or 100.4°F)

Yes No Severe, unexplained fatigue

If you answered "Yes to any of these questions, Proceed to Step 3, otherwise, this requirement is completed when you sign below.

Student's Signature: _____ Date: _____

Step 3 Chest X-Ray

You must have a chest x-ray prior to arrival at Clarkson University and attach a copy of the report to this form.

Chest X-Ray date: _____ Chest X-Ray results: _____

Health Care Provider signature: _____ Date _____

Dear Student and Parent:

As the Director of the Student Health Center at Clarkson University, I am writing to inform you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis, and a new law in New York State. On July 22, 2003, Governor Pataki signed New York State Public Health Law (NYS PHL) 2167 requiring institutions, including colleges and universities, to distribute information about meningococcal disease and vaccination to all students meeting the enrollment criteria, whether they live on or off campus. This law became effective on August 15, 2003.

Clarkson University is required to maintain a record of the following for each student:

- A record of meningococcal meningitis immunization within the past 10 years: (Immunization Report Part II)

or

- An acknowledgement of meningococcal disease risks and refusal of meningococcal meningitis immunization signed by the student or student's parent or guardian. (Part II of the immunization report)

Meningitis is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. If not treated early, meningitis can lead to swelling of the fluid surrounding the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even death. Causes of meningitis among teens and young adults 15-24 years of age (the age of most college students) have more than doubled since 1991. The disease strikes about 3,000 Americans each year and claims about 300 lives. Between 100 and 125 meningitis cases occur on college campuses and as many as 15 students will die from the disease.

A vaccine is available that protects against four types of the bacteria that cause meningitis in the United States – types A, C, Y, and W-135. These types account for nearly two thirds of meningitis cases among college students.

The vaccine is normally available at the Student Health Center. Please call for the current cost. The vaccine is also available at our St. Lawrence County Public Health Department. You may call them at 315-386-2325 for their current cost. I encourage you and your child to carefully review the enclosed materials. Please complete the Meningococcal Meningitis Response Form only if you do not have valid documentation for vaccination of meningoccal disease and return it to: Student Health Center, Clarkson University, Box 5643, Potsdam, NY 13699-5643.

NOTE: 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 TO 60 DAYS IF A STUDENT CAN SHOW A GOOD FAITH EFFORT TO COMPLY.

To learn more about meningitis and the vaccine, please feel free to contact our Student Health Center and/or consult your child's physician.

Sincerely,

Susan Knowles MSN FNP-BS
Director of Student Health Center
Clarkson University

NEW YORK STATE DEPARTMENT OF HEALTH

Bureau of Communicable Disease Control

Meningococcal Disease

What is meningococcal disease?

Meningococcal disease is a severe bacterial infection of the bloodstream or meninges (a thin lining covering the brain and spinal cord) caused by the meningococcus germ.

Who gets meningococcal disease?

Anyone can get meningococcal disease, but it is more common in infants and children. For some adolescents, such as first year college students living in dormitories, there is an increased risk of meningococcal disease. Every year in the United States approximately 2,500 people are infected and 300 die from the disease.

How is the germ meningococcus spread?

The meningococcus germ is spread by direct close contact with nose or throat discharges of an infected person.

What are the symptoms?

High fever, headache, vomiting, stiff neck and a rash are symptoms of meningococcal disease. The symptoms may appear 2-10 days after exposure, but usually within 5 days. Among people who develop meningococcal disease, 10-15% die, in spite of treatment with antibiotics. Of those who live, permanent brain damage, hearing loss, kidney failure, loss of arms or legs, or chronic nervous system problems can occur.

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 (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?

In February 2005, the CDC recommended a new vaccine, known as Menactra, for use to prevent meningococcal disease in people 11-55 years of age. The previously licensed version of this vaccine, Memomune, is available for children 2-10 years old and adults older than 55 years. Both vaccines are 85% to 100% effective in preventing the 4 kinds of the meningococcus germ (types A, C, Y, W-135). These 4 types cause about 70% of the disease in the United States. Because the vaccines do not include type B, which accounts for about one-third of cases in adolescents, they do not prevent all cases of meningococcal disease.

Are the vaccines safe? Are there adverse side effects to the vaccine?

Both vaccines are currently available and both are safe and effective vaccines. However, both vaccines may cause mild and infrequent side effects, such as redness and pain at the injection site lasting up to two days.

Who should get the meningococcal vaccine?

The vaccine is recommended for all adolescents entering middle school (11-12 years old) and high school (15 years old), and all first year college students living in dormitories. However, the vaccine will benefit all teenagers and young adults in the United States. Also at risk are people with terminal complement deficiencies or asplenia, some laboratory workers, and travelers to endemic areas of the world.

What is the duration of protection from the vaccine?

Menomune, the older vaccine, requires booster doses every 3 to 5 years. Although research is still pending, the new vaccine, Menactra, will probably not require booster doses.

How do I get more information about the meningococcal disease and vaccination?

Contact your family physician or your student health service. Additional information is also available on the websites of the New York State Department of Health, www.health.state.ny.us; the Centers for Disease Control and Prevention www.cdc.gov/ncid/dbmd/diseaseinfo; and the American College Health Association, www.acha.org.

To Parents and Guardians of Applicants Under Eighteen:

In order to procure quickly any emergency care that may be necessary for students and at the same time to protect the health care providers and the institutions involved, it is requested that you sign the consent for emergency treatment below.

Be assured that we will make every effort to notify parents at once in the case of serious accidents or illnesses when these come to our attention, but since students often come great distances, this may be slow or impossible even by phone. Your cooperation in this matter therefore is much appreciated.

I _____, pursuant to the authority vested in me as the
_____ of _____,
Parent – Guardian Student’s Full Name

do hereby authorize the Student Health Center staff at Clarkson University upon consultation with a practicing physician or surgeon to exercise for me and on my behalf, all rights and duties with reference to consenting to appropriate medical, psychiatric, and surgical treatment, anesthetics, medicines and hospitalization, including care and treatment, by any hospital, staff surgeon, physician or radiologist which they deem necessary for the emergency care of my, _____,
Son – Daughter Student’s Full Name

Signed _____ Date _____

Please return to:
Student Health Center
Clarkson University
Box 5643
Potsdam, NY 13699-5643