

**Check one box and sign below.**

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

had meningococcal immunization within the past five years. The vaccine record is attached.

Note: The Advisory Committee on Immunization Practices recommends that all first-year college students up to age 21 years should have at least one 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 students should discuss the Meningococcal B vaccine with a health care provider.

read or have had explained to me, the information regarding meningococcal disease. I (my child) will obtain immunization against meningococcal disease **within 30 days** from my private health care provider or Farmingdale State College Health and Wellness Center.

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.

\_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Signed** (Parent/Guardian if student is a minor)

\_\_\_\_\_ Students Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

**Print Student's Name**

\_\_\_\_\_ Student's E-mail Address \_\_\_\_\_ Student RAM ID# \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_ Student's Mailing Address \_\_\_\_\_

\_\_\_\_\_ Student's Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_

About Meningococcal Disease

**What is meningococcal disease?**

Meningococcal disease is caused by bacteria called Neisseria meningitis. It can lead to serious blood infections. When the linings of the brain and spinal cord become inflamed, it is called meningitis. The disease strikes quickly and can have serious complications, including death.

Anyone can get meningococcal disease. Some people are at higher risk.

This disease occurs more often in people who are:

- Teenagers or young adults.
- Infants younger than one year of age.
- Living in crowded settings, such as college dormitories or military barracks
- Traveling to areas outside of the United States, such as the "Meningitis belt" in Africa.
- Living with a damaged spleen or no spleen.
- Being treated with Soliris® or who have complement component deficiency (an inherited immune disorder).
- Exposed during an outbreak.
- Working with meningococcal bacteria in a laboratory.

**What are the symptoms?**

Symptoms appear suddenly - usually three to four days after a person is infected. It can take up to 10 days to develop symptoms. Symptoms may include:

- A sudden high fever
- Headache
- Stiff neck (meningitis)
- Nausea and vomiting

- Red-purple skin rash
- Weakness and feeling very ill
- Eyes sensitive to light

**How is meningococcal disease spread?**

It spreads from person-to-person by coughing or coming into close or lengthy contact with someone who is sick or who carries the bacteria. Contact includes kissing, sharing drinks, or living together. Up to one in 10 people carry meningococcal bacteria in their nose or throat without getting sick.

**Is there treatment?**

Early diagnosis of meningococcal disease is very important. If it is caught early, meningococcal disease can be treated with antibiotics. But, sometimes the infection has caused too much damage for antibiotics to prevent death or serious long-term problems. Most people need to be cared for in a hospital due to serious, life-threatening infections.

**What are the complications?**

Ten to 15 percent of those who get meningococcal disease die. Among survivors, as many as one in five will have permanent disabilities.

Complications include:

- Hearing loss
- Brain damage
- Kidney damage
- Limb amputations

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**A health form is required for all full-time students.** (Complete pages 1 and 2 before going to your health care provider for physical examination.)

The information requested on this form is for the use of the Health and Wellness Center and will not be released to anyone without your knowledge and consent except as required by law.

You may go into the OASIS registration system to read and electronically submit the Meningitis Letter.

Date: \_\_\_\_\_ Name: \_\_\_\_\_  
Last First Middle

RAM ID #: R \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex: M F Other Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ Cell Phone: ( \_\_\_\_\_ ) \_\_\_\_\_  
Number Street Apt

\_\_\_\_\_ Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_  
Town State Zip Code Country

Email: \_\_\_\_\_ Are you planning to reside on campus?  Yes  No Are you an athlete?  Yes  No

What is your major? \_\_\_\_\_

**In Case of Emergency Contact:**

\_\_\_\_\_ Name and relationship of person to be notified

\_\_\_\_\_ Number Street

\_\_\_\_\_ City State Zip

( \_\_\_\_\_ ) \_\_\_\_\_ ( \_\_\_\_\_ ) \_\_\_\_\_  
Home telephone Business telephone

**Do you have medical insurance?**  Yes  No (If yes, please attach copy of insurance card.)

If you are interested in or have any questions regarding the College Insurance Plan, please contact the Insurance Claims Specialist at (631) 420-2154.

**PARENTAL CONSENT FOR MEDICAL CARE OF STUDENTS UNDER 18 YEARS OF AGE**

\_\_\_\_\_ Parent/Guardian Signature Relationship to student Date

### PHYSICAL EXAMINATION

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

<p>1. Skin _____</p> <p>2. Eyes _____</p> <p>3. Ears _____</p> <p>4. Nose/Sinuses _____</p> <p>5. Mouth/Thyroid/Dental _____</p> <p>6. Neck/Thyroid _____</p> <p>7. Heart _____</p> <p>8. Lungs/Chest _____</p> <p>9. Breasts _____</p> <p>10. Abdomen _____</p> <p>11. Nervous System _____</p> <p>12. Extremities/Joints _____</p> <p>13. Back _____</p> <p>14. Genitourinary System _____</p> <p>15. Emotional/Mental Status _____</p> <p>DATE OF PHYSICAL EXAM _____</p> <p>For females, Date of LMP _____</p>	<p><b>VISION</b></p> <p>Glasses <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Contacts <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Eye Glass Prescription _____</p> <p><b>LAB WORK</b></p> <p>MANTOUX TEST FOR TB (within 1 year)</p> <p>Date of Test _____</p> <p>Date of Reading _____</p> <p>Results in millimeters _____</p> <p>If mantoux is positive (&gt;10mm):</p> <p style="padding-left: 40px;">Date of chest x-ray _____</p> <p style="padding-left: 40px;">Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative</p> <p>If recent converter or chest x-ray positive, explain treatment _____</p> <p>_____</p> <p>_____</p>
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Please list all allergies \_\_\_\_\_

\_\_\_\_\_

Recommendations for physical activity:  Unlimited  Limited (with explanation below)

Recommendations regarding care of this student (with explanation below)

Student now under treatment for medical or emotional condition (with explanation below)

**FOR STUDENTS WHO PLAN TO PARTICIPATE IN ATHLETICS**

Student is fully cleared to participate in athletics.  Attach Athletic Cardiac Questionnaire (ATTACH COPY)

Have you consulted or been treated by a psychiatrist, clinical psychologist, social worker, or other counselor?  Yes  No

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

Are you taking any medications?  Yes  No

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

If you have been hospitalized or have any medical problems, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### IMMUNIZATION REQUIREMENTS

New York State law and Farmingdale State College, in keeping with recommendations of the American College Health Association and the Centers for Disease Control, require all students born on or after January 1, 1957 who are attending an institution of higher education to show proof of two doses of live measles vaccine, one dose of live mumps vaccine and one dose of live rubella vaccine, given after one year of age. In lieu of immunization dates, the physician may provide a date of disease for measles and mumps only; history of rubella disease is not acceptable. Student may also choose to have blood tests called titers in lieu of immunizations which will show actual levels of immunity to each of the three diseases. If titers are drawn, please attach copies of actual laboratory reports.

	DATE	DATE	DATE	DATE OF DISEASE	TITER DATE + RESULTS
					Attach actual lab report
<b>MMR</b>					
<b>MEASLES</b>					
<b>MUMPS</b>					
<b>RUBELLA</b>					
<b>RECOMMENDED HEPATITIS-B</b>					
<b>RECOMMENDED VARICELLA</b>					
<b>TETANUS-DIPHTHERIA</b> <small>within 10 years</small>					
<b>MENINGOCOCCAL</b> <small>within 5 years for resident students required</small>					

**ALL NURSING, DENTAL HYGIENE AND MEDICAL LABORATORY TECHNOLOGY STUDENTS MUST SUBMIT THE FOLLOWING TITERS, WHICH ARE REQUIRED FOR THEIR CLINICAL ROTATIONS:**

Hepatitis B <i>(or proof of shots)</i>	Measles	Mumps
Rubella	Varicella	

Please use grid above to enter information. Please attach copies of laboratory reports for all titers.

Provider's Signature \_\_\_\_\_

Print Name \_\_\_\_\_

Address \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

Fax (\_\_\_\_) \_\_\_\_\_

**RETURN THIS FORM TO:**  
 Health and Wellness Center  
 Farmingdale State College  
 2350 Broadhollow Road  
 Farmingdale, NY 11735

**OFFICE STAMP**