Farmingdale State College
State University of New York

Student Medical History

A health form is required for all full-time students. *(Complete page 1 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.

Date: _____ **Name:** _____
Last First Middle

RAM ID #:_____ **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
**If yes, please disregard this form and fill out the New Student Athlete form.*

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.)*

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

_____
Parent/Guardian Signature Relationship to student Date

LAST NAME, FIRST_____ RAM ID_____

MEDICAL HISTORY

Please list all allergies: _____

_____

Please list all medications: _____

_____

Please list all medical or surgical history:_____

_____

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

If yes, please explain: _____

_____

IMMUNIZATION REQUIREMENTS

If blood titers were drawn, please attach lab report

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.

IMMUNIZATION	DATE	DATE	DATE
MMR			
MEASLES			
MUMPS			
RUBELLA			

IMMUNIZATION	DATE	DATE	DATE
HEPATITIS B			
MENINGOCOCCAL *within 5 years for resident students required*			
TDAP *within 10 years*			

Provider's Signature *Required* _____

Print Name _____

Address_____

Phone (_____)_____ **Fax (_____)** _____

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

OFFICE STAMP *REQUIRED*

Farmingdale State College
State University of New York

Tuberculosis Screening

Last Name, First, MI: _____ **RAM ID #:** _____

Country of Birth: _____ **Year arrived in US:** _____

SECTION A:

1. **Have you ever had a positive PPD, TB Quantiferon test, or T-SPOT?** ☐ **Yes** ☐ **No**
   (If yes, please provide details in Section C below.)

SECTION B:

1. **Were you born in, or have you lived, worked or visited for more than one month in any of the following: Asia, Africa, South America, Central America or Eastern Europe?** ☐ **Yes** ☐ **No**

If yes, what country? _____ **How long?** _____

2. **Do any of the following conditions or situations apply to you?**

   a) **Do you have a persistent cough? (3 weeks or more), fever, night sweats, fatigue, loss of appetite, or weight loss?** ☐ **Yes** ☐ **No**

   b) **Have you ever lived with or been in close contact to a person known or suspected of being sick with TB?** ☐ **Yes** ☐ **No**

   c) **Have you ever lived, worked, or volunteered in any homeless shelter, prison/jail, hospital or drug rehabilitation unit, nursing home or residential healthcare facility?** ☐ **Yes** ☐ **No**

Student Signature _____ **Date** _____

If you answered no to all of the above questions, skip Section C.

If you answered yes to any of the above questions, your medical provider must complete Section C below.

SECTION C:

ATTENTION MEDICAL PROVIDER: If patient answered YES to any of the above questions, a TB test (PPD, T-Spot , or TB QuantiFERON) is REQUIRED. History of BCG vaccination does not exclude patient from this requirement. Test must be done within one calendar year (unless history of positive TB test). If PPD results are 10mm or more, or T-Spot or TB QuantiFERON are positive, a chest x-ray is REQUIRED. For students with history of positive TB test, documentation of dates & results of testing and chest x-ray, as well as treatment information, must be documented below. It is not necessary for these students to repeat TB testing or CXR.

PPD Date Placed: _____ **PPD Date Read:** _____ **Measurement in mm induration:** _____

OR

QuantiFERON-TB Gold or T-Spot Result Date: _____ **QFT-G or T-Spot Result:** ☐ **Positive** ☐ **Negative** ☐ **Equivocal**
Please attach lab report

If PPD results are 10mm or more, or QuantiFERON-TB Gold or T-SPOT results are positive, a chest x-ray is REQUIRED. *(Please attach copy of report.)*

Chest X-Ray Date: _____ **Chest X-Ray Results:** _____

If negative CXR and positive PPD/Lab Result, did the patient complete a course of INH or other TB Treatment? ☐ **Yes** ☐ **No**

If yes, name & dose of medication: _____

Date Range of Treatment: _____ **How many months did student take medication? (# of months)** _____

PROVIDER INFORMATION REQUIRED

Signature/Stamp of medical provider _____ **Phone number of practice** _____ **Date** _____

Farmingdale State College
State University of New York

Meningococcal Vaccination Response Form

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 *(Student MUST sign, if under 18, parent/guardian must sign.)*

_____ **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