Dear Incoming Student,

Welcome to The College of Saint Rose! Each international student is required to provide the following information to the College's Health Service office. Many of these requirements are required by the New York Department of Health.

All forms need to be completed by September 16th for Fall semester, and February 6th for Spring semester.

- ☐ Complete Immunization Record. **Health Care Provider Signature Required.**
- ☐ Complete Meningococcal Meningitis Record. **Health Care Provider Signature Required.**
- ☐ Complete Medical History.
- ☐ Complete Physical Evaluation. **Health Care Provider Signature Required.**
- ☐ Complete Tuberculosis Screening. **Health Care Provider Signature Required.**
- ☐ Copy of Medical Insurance Card. **Front and back of card.**

All of these forms can be uploaded to the medical portal that can be found on the Health Services website:

https://www.strose.edu/student-development/health-counseling-wellness/health-services/required-health-forms/

If you have any questions about what is required contact Health Services by email at healthservices@strose.edu or by phone at (518) 454-5244.

The Health Services clinic is open during the academic year and offer the following services:

Same Day Services by Appointment

- Evaluation and treatment for ACUTE ILLNESS with testing and medications
- OTC Medication dispensing
- First aid for non-life threatening injuries
- Assistance with visits to specialists and with student permission collaboration with Counseling Services as needed
- Hospital follow-up
- Personal health education

Additional Services

DMV Eye Exams
Old meds/sharps disposal

On Site Rapid Testing

Rapid Strep
Rapid Flu A&B
Rapid Mono Spot
COVID-19 Rapid Antigen and Rapid Molecular
Rapid Urine Pregnancy

THE HEALTH SERVICES CLINIC DOES NOT PROVIDE THE FOLLOWING SERVICES AT THIS TIME: ALLERGY INJECTIONS, ORAL OR INJECTABLE BIRTH CONTROL, DAILY MEDICATIONS FOR CHRONIC ILLNESS AND PELVIC EXAMS/PAPS.

Sincerely,

Health Services

Quick Instructions for Forms

Immunization Record

New York State Law requires all students born on or after January 1, 1957 registering for six or more credits to prove immunity to measles, mumps, and rubella (MMR). **This form must be signed and stamped by a medical provider, or accompanied by an immunization record that is stamped by a medical provider.**

- 2 doses of live measles vaccine (or the combined MMR), with the 1st dose given no more than 4 days prior to the student's first birthday and the second dose at least 28 days after the first dose.
- 1 dose of live mumps vaccine (or the combined MMR), with the 1st dose given no more than 4 days prior to the student's first birthday.
- 1 dose of live rubella vaccine (or the combined MMR), with the 1st dose given no more than 4 days prior to the student's first birthday

OR

- Serological proof of immunity to measles, mumps and rubella through a lab report from an approved medical laboratory confirming immunity.

Meningococcal Meningitis Record

The meningitis vaccine is not required, however, all students registering for six or more credits must submit one of the following:

- Certificate of immunization for meningococcal meningitis disease within the past five years; or
- An acknowledgement of meningococcal disease risks and refusal of meningococcal meningitis immunization signed by the student (or student's parent or guardian if under the age of 18).

Report of Medical History

This form is required for all students and is to be completed and signed by the student (or student's parent or guardian if under the age of 18). **A medical provider does not complete this form.**

Report of Physical Evaluation

This form must be used to document a physical evaluation completed within 1 year of arrival date on campus for International and Resident Students, or within 6 months of arrival date on campus for Athletes. We cannot accept proof of a physical on any other form. Physical Evaluations must be completed by a physician, physician assistant or nurse practitioner.

Tuberculosis Screening

The Tuberculosis Screening form must be completed, signed and stamped by a medical provider. If the answer is no to all 3 questions, no additional information is needed.

If the answer is yes to any of the questions, additional documentation/testing is needed and outlined on the form.

IMMUNIZATION RECORD

The College of Saint Rose

Name:_____ Student ID: _____

Address:_____ Phone: _____

City:_____ Cell: _____

State:_____ Zip:_____ Date of Birth: _____

HEALTH CARE PROVIDER OR SCHOOL OFFICIAL PLEASE READ AND COMPLETE THIS FORM, THANK YOU.

New York State Public Health Law 2165 requires post-secondary students to show proof of immunity to **MEASLES, MUMPS and RUBELLA**. *Persons born prior to January 1, 1957 or taking less than six credits in a semester are exempt from this requirement.* **Immunization #1 in Option 1 must have been given after the first birthday**.

REQUIRED VACCINES (Option 1 or 2) :

Option 1: Two Doses of Measles, Mumps, Rubella (MMR) Vaccine - (Dose #1 given **after** First birthday)

MMR #1 _____/_____/_____ AND MMR #2 _____/_____/_____
Month Day Year Month Day Year

Option 2: Positive MMR Antibody Titers

( ) ✓ Positive MMR Antibody Titers
MUST ATTACH COPY OF LAB REPORT
Attached certificates of immunization will be ***Accepted ONLY IF signed stamped by health care provider****.*

RECOMMENDED VACCINES:

COVID-19 All Saint Rose students are recommended to be fully vaccinated against COVID-19

Vaccine Name _____ *example: Pfizer*

_____/_____/_____, _____/_____/_____, _____/_____/_____, _____/_____/_____

Tetanus: _____/_____/_____ **Varicella**: _____/_____/_____, _____/_____/_____

Hepatitis B Series: _____/_____/_____, _____/_____/_____, _____/_____/_____

Attached certificates of immunization will be accepted ***ONLY IF*** *signed/stamped by health care provider*

Health Care Provider Signature & Stamp Required

Stamp

Signature_____

Date: _____

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(518) 454-5244 • Fax (518) 454-2007

Rev. 01.2023

MENINGOCOCCAL MENINGITIS RECORD

The College of Saint Rose

Name:_____ Student ID: _____

Address:_____ Phone: _____

City:_____ Cell: _____

State:_____ Zip:_____ Date of Birth: _____

At least 1 dose of Meningococcal ACWY vaccine not more than 5 years before enrollment is recommended.

(Meningitis vaccination or waiver is REQUIRED of all students– See Below for Student Waiver)

Recommended Vaccine:

MENINGOCCAL ACWY Name _____ Date: _____/_____/_____
Month Day Year

MENINGOCCAL ACWY Name _____ Date: _____/_____/_____
Month Day Year

Health Care Provider Signature & Stamp Required

Stamp:

Signature: _____

Date: _____

Attached certificates of immunization will be accepted ONLY IF signed & stamped by health care provider.

STUDENT WAIVER

Required Meningococcal Meningitis Response

TO BE COMPLETED BY STUDENT OR PARENT/GUARDIAN

Please review the vaccine information on the back of this form. If you have chosen not to have the meningitis vaccine, complete the following waiver by signing and dating the statement below.

I have received and reviewed the Meningococcal Meningitis vaccine information provided on the back of this form. I understand the risks of Meningococcal Meningitis and the benefit of immunization and have decided that I will NOT obtain immunization against Meningococcal Meningitis

Signed:_____ Date: _____

Signature of Student or Parent/Guardian if student is under eighteen.

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Rev. 12.2021

Meningococcal Meningitis Information

The College of Saint Rose is required to maintain a record of the following for each student:

- A response to receipt of meningococcal disease and vaccine information signed by the student or student's parent or guardian
  AND EITHER
- A record of meningococcal immunization within the past 5 years; OR
- An acknowledgement of meningococcal disease risks and refusal of meningococcal immunization signed by the student or student's parent or guardian.

Meningococcal disease is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. Meningococcal disease can cause serious illnesses such as infection of the lining of the brain and spinal column (meningitis) or blood infections (sepsis). The disease strikes quickly and can lead to severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even lead to death.

Meningococcal disease can be easily spread from person-to-person by coughing, sharing beverages or eating utensils, kissing, or spending time in close contact with someone who is sick or who carries the bacteria. People can spread the bacteria that cause meningococcal disease even before they know they are sick. There have been several outbreaks of meningococcal disease at college campuses across the United States. Up to one in 10 people carry meningococcal bacteria in their nose or throat without getting sick.

The single best way to prevent meningococcal disease is to be vaccinated. The meningococcal ACWY (MenACWY) vaccine protects against four major strains of bacteria which cause about two-thirds of meningococcal disease in the United States (U.S.). The MenACWY vaccine is recommended for all U.S. teenagers and young adults up to age 21 years. Protection from the MenACWY vaccine is estimated to last about 3 to 5 years, so young adults who received the MenACWY vaccine before their 16th birthday should get a booster dose before entering college. The meningococcal B (MenB) vaccine protects against a fifth type of meningococcal disease, which accounts for about one-third of cases in the
U.S. Young adults aged 16 through 23 years may choose to receive the MenB vaccine series. They should discuss the MenB vaccine with a healthcare provider.

All private insurance plans not grandfathered under the Affordable Care Act are required to cover the cost of MenACWY and MenB vaccines. Contact your health insurance plan to determine whether it covers MenACWY and MenB vaccines. The federal Vaccines for Children (VFC) and NYS Vaccines for Adults (VFA) programs will cover both MenACWY and MenB vaccines for children and adults who have no health insurance or whose health insurance does not cover these vaccines, as well as for children less than 19 years of age who are American Indian or Alaska Native or eligible for Medicaid or Child Health Plus.

The College of Saint Rose Health Service does not provide immunizations. Please check with your insurance provider to find participating locations and coverage. The vaccine is available through county health departments and locally at the Albany County Department of Health, 175 Green Street, Albany, NY 12202 Phone: (518) 447-4580.Prices range from $18 to $140 please call to verify eligibility.

To learn more about meningococcal disease and the vaccine, please feel free to contact our health service and/or consult your child's physician. You can also find information about meningococcal disease and the vaccine at the Centers for Disease Control and Prevention website at www.cdc.gov/meningococcal/ and the New York State Department of Health website at www.health.ny.gov/publications/2168.pdf.

MEDICAL HISTORY

Name:_____ Student ID: _____

Address:_____ Phone: _____

City:_____ Cell: _____

State:_____ Zip:_____ Date of Birth: _____

Allergies to medications, foods, or stinging insects: ☐ **No** ☐ **Yes, List** _____

Medications regularly taken or required: ☐ **No** ☐ **Yes, List** _____

Personal History; ☐ Check ✓ for : <u>No significant medical history, no to all below.</u>
<u>Or</u> Check ✓ "Yes" and explain below or check the following box:

Cardiac Disease	☐ Yes, _____	Gastrointestinal Disorder	☐ Yes, _____
High Blood Pressure	☐ Yes, _____	Marfan's Syndrome	☐ Yes, _____
Heart Murmur	☐ Yes, _____	Diabetes	☐ Yes, _____
Surgery	☐ Yes, _____	Skin Disorder	☐ Yes, _____
Cancer	☐ Yes, _____	Arthritis	☐ Yes, _____
Anemia	☐ Yes, _____	Orthopedic/Spine Disorder	☐ Yes, _____
Clotting Disorder	☐ Yes, _____	Seizure Disorder	☐ Yes, _____
Sickle Cell Trait	☐ Yes, _____	Head Injury	☐ Yes, _____
Asthma	☐ Yes, _____	Migraine	☐ Yes, _____
Kidney Disease/UTI	☐ Yes, _____	Mononucleosis	☐ Yes, _____
Tuberculosis	☐ Yes, _____	Chicken Pox	☐ Yes, _____
Thyroid Disease	☐ Yes, _____	Other	☐ Yes, _____

Family History

Father: ☐ Living ☐ Deceased, age at death and cause _____ Mother: ☐ Living ☐ Deceased, age at death and cause _____

Has any immediate family member ever had?

Cardiac Disease	□ Yes □ No	Marfan's Syndrome	□ Yes □ No	Asthma	□ Yes □ No	Tuberculosis	□ Yes □ No	Thyroid Disease	□ Yes □ No
Sudden Cardiac Death	□ Yes □ No	Sickle Cell Trait	□ Yes □ No	Seizure Disorder	□ Yes □ No	Stroke	□ Yes □ No	Clotting Disorder	□ Yes □ No
High Blood Pressure	□ Yes □ No	Cancer	□ Yes □ No	Diabetes	□ Yes □ No	Kidney Disease	□ Yes □ No	DVT	□ Yes □ No

Emergency contact:

Name: _____ Relationship: _____ Phone Number: _____

CONSENT TO TREATMENT AND FINANCIAL RESPONSIBILITY

I hereby give permission for the above student to receive general, diagnostic and therapeutic medical treatment or counseling services from the College of Saint Rose Health Service, Counseling and Psychological Services or such other health care provider as The College of Saint Rose shall determine necessary. This includes examinations and treatments for all medical problems, psychological issues, and/or injuries incurred while the student is attending The College of Saint Rose and all consultative care by external health care providers including hospitalization, anesthesia, surgery or other treatments

I hereby give permission to the Counseling Center and Health Services at The College of Saint Rose to exchange information and records relative to my medication management and mental and physical health.

This means that the Counseling Center has my authorization to release and receive records pertaining to my medication management and mental and physical health with Health Services. Additionally, Health Services has my authorization to release and receive records pertaining to my medication management and mental and physical health with the Counseling Center.

The undersigned student and parent/guardian accept financial responsibility for the expense of health care services, diagnostic and therapeutic medical treatment or counseling services rendered to the above student by The College of Saint Rose Health Service, Counseling and Psychological Services or such other health care provider as The College of Saint Rose shall determine necessary. If you have health insurance, provide the name of company and policy number. Include the phone number from back of card or attach a copy of the card.

ATHLETES ONLY I hereby give permission to Sports Medicine and Health Services at The College of Saint Rose to exchange information and records relative to my physical health.

_____

Company name Policy number Phone Number

Signature of Student _____ **Date** _____

For students under age 18:

I give permission for the above named student to receive the medical treatment and counseling services and accept financial responsibility for that treatment:

Print Name of Parent/Guardian: _____

Signature of Parent/Guardian _____ **Date** _____

PHYSICAL EVALUATION

The College of Saint Rose

Name:_____ Student ID: _____

Address:_____ Phone: _____

City:_____ Cell: _____

State:_____ Zip:_____ Date of Birth: _____

- ***To be completed within 1 year of arrival date on campus for International and Resident Students.***
- ***To be completed within 6 months of arrival date on campus for Athletes.***

Physical Evaluation must be completed by a Physician, Physician Assistant or Nurse Practitioner.

Practitioner please complete THIS form fully; other physical forms will NOT be accepted. EACH question must be answered or the document will not be accepted.

Date of Physical:_____

Height:_____ Blood Pressure:_____ Vision (R)_____ (L) _____

Weight:_____ Pulse Rate:_____ Glasses/Contacts _____

General Appearance	□ Normal	□ Abnormal	**Lungs**	□ Normal	□ Abnormal
Skin	□ Normal	□ Abnormal	**Neck/Spine**	□ Normal	□ Abnormal
Eyes	□ Normal	□ Abnormal	**Heart/Pulses**	□ Normal	□ Abnormal
Ears, Nose and Throat	□ Normal	□ Abnormal	**Abdomen**	□ Normal	□ Abnormal
Tonsils	□ Normal	□ Abnormal	**Extremities**	□ Normal	□ Abnormal
Teeth and Gums	□ Normal	□ Abnormal	**Breasts**	□ Normal	□ Abnormal
Thyroid	□ Normal	□ Abnormal	**Genitalia**	□ Normal	□ Abnormal

Explain abnormal responses above: _____

Any chronic or current illness: ☐ No ☐ Yes Explain: _____

_____

Allergies to medications, foods, or stinging insects: ☐ NKDA ☐ Yes List: _____

_____

Medications regularly taken or required: ☐ No ☐ Yes List: _____

Is student cleared for full athletic participation? □ Yes □ No Restriction(s): _____

_____

Health Care Provider Signature & Stamp Required

Stamp

Signature_____

Date: _____

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TUBERCULOSIS SCREENING

The College of Saint Rose

Name:_____ Student ID: _____

Address:_____ Phone: _____

City:_____ Cell: _____

State:_____ Zip:_____ Date of Birth: _____

Home Country:_____

ALL 3 QUESTIONS MUST BE ANSWERED

1. Does the student have **history** of a positive tuberculin test (TST) or positive Interferon-gamma release assay (attach laboratory result? **Yes**____ **No**____

   If yes, ☐ History of Positive PPD Date: _____

   ☐ History of Positive IGRA Date: _____

   *Chest X-ray is required within 6 months prior to arrival to campus for students with history of positive PPD or IGRA. **Attach radiology report.**

2. Does the student have signs or symptoms of active TB disease such as night sweats, weight loss, persistent cough or bloody sputum? **Yes**____ **No**____

3. Is the student a member of a high risk group? **Yes**____ **No**____

Categories of high-risk students include those who have arrived within the past five years from countries where TB in endemic. It is easier to identify countries of low rather than high TB prevalence.

Categories of high-risk students include those who have arrived within the past five years from countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence.
Students should undergo TB testing if they have arrived from another country with the exception of:
Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia, USA, 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, leukemia 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. Adapted from ACHA's Vaccine-Preventable Disease Task Force.

If no to all questions above, no additional information is necessary.
If YES to question #2 or #3 above, additional testing is required, complete below. A history of BCG vaccination does not preclude testing a member of a high-risk group. Testing needs to have been performed **within the six months** prior to the start of the semester.

Tuberculosis Skin Test

Date Placed:_____/_____/_____ Date Read:_____/_____/_____ Result:_____mm induration

Treatment (list medication and duration of treatment):_____

-OR-

Interferon-gamma Release Assay. **ATTACH RADIOLOGY REPORT.**

A chest X-ray is required within 6 months prior to arrival to campus for students with new or history of positive PPD or IGRA. ATTACH RADIOLOGY REPORT.

Health Care Provider Health Care Provider Signature & Stamp Required

Stamp

Signature_____

Date: _____

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