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Counseling and Health Services
 Foreman Hall, 2 Main St.
 Delhi, NY 13753
 Phone (607) 746-4690 Fax (607) 746-4141
 email: healthservices@delhi.edu
 web page: www.delhi.edu

<u>For Health Center use only</u>	
Input	_____
Rev'd by	_____
HC	_____

HEALTH HISTORY

Information provided on this form is CONFIDENTIAL and is used for your health and safety while you are a student. Information will be released only with your written permission, with a court order or in case of serious medical emergency.

Identification:

SS#: _____ SUNY ID#: _____

Birth Date (Month/Day/Year): _____

Year Entering: _____ Fall _____ Spring

Student Status: Freshman Transfer Re-admit/Re-entry

Major: _____

NAME (Print) _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

STUDENT CELL PHONE #: _____

STUDENT EMAIL ADDRESS: _____

Telephone Number (Home): _____

Gender: Male _____ Female _____

PERSON TO NOTIFY IN CASE OF EMERGENCY:

Name _____ Relationship _____

Address _____

Home Phone _____ Cell Phone _____ Business Phone _____

HEALTH INSURANCE INFORMATION: (Complete below OR attach FRONT & BACK copy of insurance card)

Insurance Company Name _____

Insurance Company Address _____

City _____ State _____ Zip _____

Insurance Company's Phone No. _____

Plan Code _____ Group Number _____

Insured's Name _____ Policy ID# _____

Insured's Employer _____

Primary Care Provider (if applicable) _____ Phone No. _____

STUDENT HEALTH INSURANCE IS REQUIRED FOR ALL STUDENTS WHO ARE NOT COVERED BY ANOTHER HEALTH INSURANCE POLICY

Release between O'Connor Hospital of Delhi, NY and SUNY Delhi Health Services:

I agree to allow O'Connor Hospital in Delhi to provide the SUNY Delhi Health Service with information concerning any medical treatments I may require while a student at the college. I understand that this medical information is necessary for appropriate follow-up care by the SUNY Delhi Health Service, should I be treated at O'Connor Hospital.

Student Signature _____ Date _____

List any significant past and current medical problems such as asthma, diabetes, seizure disorder, immune deficiency disease, tuberculosis or other: _____

List all medications taken regularly*: _____

**You should arrange to get prescriptions from your primary care provider while at college.*

Hospitalizations/surgeries and dates: _____

Do you have any drug or food allergies? _____

Will you be receiving allergy injections while at SUNY Delhi? _____

Have you received treatment or counseling from a psychiatrist, psychologist or counselor? _____

Do you request counseling at SUNY Delhi? _____

Are you disabled in any way that requires you to receive special accommodations at SUNY Delhi? (Please circle)

Emotional Hearing Learning Mobility Speech Vision

Other _____

Students with disabilities: If you are in need of accommodations or services, please contact the Coordinator of Services for Students with Disabilities at (607) 746-4593.

The information on this health form cannot be shared with that office without your written permission.

OVER → →

PLEASE PRINT IN BLACK INK

Social Security or Student ID# _____

Name: Last _____ First _____ Middle _____ Birth date: _____

PART A: MENINGITIS INFORMATION - SIGNATURE REQUIRED (New York State law requires completion of this section).

I have (or for students under 18, my child has) (Please check one):

_____ read, or have had explained to me, the information regarding meningococcal meningitis disease. I am aware that immunization against this disease is strongly recommended and available at Student Health Services for a fee or from any health care provider. I decline the vaccine or may elect to have it in the future.

- OR -

_____ had the meningococcal immunization within the past 10 years.

For more information about Meningitis, go to www.delhi.edu/campus_life/health_services/meningitis_info.php

Signature of student (or parent/guardian if under 18) _____ Date _____

PART B: IMMUNIZATION RECORD - MUST BE SUBMITTED BY ALL STUDENTS BORN ON OR AFTER JAN. 1, 1957.

		VACCINE DATE GIVEN MO/DAY/YR	SEROLOGY DATE/ RESULTS (COPY OF LAB REPORT MUST BE ATTACHED)	REQUIRED FOR NURSING MAJORS	
M A N D A T O R Y	MMR combined (2 doses)	#1 #2	N/A	2 MMR's - (2 measles, 2 mumps, 2 rubella) or copy of positive titers report	
	OR {	Measles (2 doses live vaccine on or after first birthday) and	#1 #2		
		Mumps (1 dose of live vaccine on or after first birthday) and			
		Rubella (1 dose of live vaccine on or after first birthday)			
R E C O M M E N D E D	Meningococcal Vaccine - Please specify Menactra or Menomune READ & SIGN PART A		N/A		
	TD/Tdap - Please specify		N/A	(within 10 yrs)	
	HEPATITIS B - Specify 2 or 3 dose series	#1 #2 #3		#1 #2 #3 (or positive titer)	
	VARICELLA	#1 #2		#1 #2 (or positive titer)	
	RABIES - (Recommended for Veterinary Science Students)	#1 #2 #3	N/A	N/A	

An official record must be attached or this form must be signed by a medical care provider or school official.

Signature of provider or school official (MD, NP, PA, RN) _____ Print Name _____ Date _____

PART C: PHYSICAL EXAMINATION-STRONGLY RECOMMENDED FOR ALL STUDENTS, REQUIRED FOR NURSING STUDENTS AND ATHLETES

Blood Pressure _____ Pulse _____ Height _____ Weight _____
 Skin: _____ Heart: _____
 H.E.E.N.T.: _____ Abdomen: _____
 Lymph Nodes: _____ Pelvic, Rectal, Genitalia: _____
 Lungs: _____ Skeletal & Extremities: _____
 Neurological: _____ Comments: _____

Cleared for athletic participation (check box):

Signature of Health Care Provider (MD/NP/PA) _____ Date _____ Phone / Fax _____

Printed Name _____ or OFFICE STAMP:

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TUBERCULOSIS SCREENING

PLEASE PRINT IN BLACK INK

Social Security or Student ID# _____

Name: Last _____ First _____ Middle _____ Birth date: _____

PART A: PAST DIAGNOSIS OF TUBERCULOSIS (TB)

1. Have you ever been sick with tuberculosis? YES NO
2. Have you ever had a positive mantoux test? If so, skip Part B and provide copy of chest x-ray report. A mantoux (PPD) is a skin test for tuberculosis. YES NO

PART B: TUBERCULOSIS EXPOSURE RISK QUESTIONNAIRE

1. If you were born, lived in, worked or traveled for more than one month outside the United States or Canada, where? _____ YES NO
2. Have you had HIV infection or AIDS, diabetes, leukemia, lymphoma or a chronic immune disorder? If yes, please specify _____ YES NO
3. 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? If so, where _____ YES NO
4. Do you use or have you used:
- D. Medications for cancer or transplant rejections? YES NO
- E. Oral steroid (Prednisone - 15 mg each day for more than one month)? YES NO
- F. Illicit intravenous drugs or crack cocaine? YES NO

IMPORTANT NOTICE: If you answered NO to all of the above, submit completed forms to Counseling and Health Services. If you answered YES, a PPD is required within one year of the start of classes,

PART C: PPD (REQUIRED FOR NURSING STUDENTS)

ATTENTION HEALTH CARE PROVIDER: If student answers **YES** to any of the above, a PPD is required within one year of the start of classes. If student has a history of positive PPD, or if current PPD results are 10 mm or more, a chest X-ray is required.

Date Placed (Mo/Day/Yr) _____ Date Read _____ Size of Induration X mm Reader's Initials _____
(If NEG put "0")

Signature of Health Care Provider (MD/NP/PA) _____ Date _____

Chest X-Ray: (Required ONLY if PPD is positive.) Date: _____ Results: _____

Antimicrobial Therapy - Did the student have treatment for the positive skin test?: Yes _____
Date Started _____ Date Completed _____

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Students attending SUNY Delhi are generally considered independent adults, and parental consents for medical care **for those under 18 years of age** are not routinely required. However, there are occasional situations in which a parental signature is desirable. Vaccinations and minor surgical procedures are two examples of such situations.

To avoid delay in such treatment interventions, you are encouraged to sign the authorization below for medical or emergency treatment and **RETURN THE FORM TO SUNY DELHI COUNSELING AND HEALTH SERVICES**. This consent for treatment applies only to care given at Counseling and Health Services. Should the student seek or be referred for care at an off-campus facility, the policies and procedures of that facility will be followed.

Parents and guardians are reminded that the student health fee applies only to care and treatment given at Counseling and Health Services. Full-time undergraduate students must be enrolled in an insurance plan in case off-campus care is needed. A student sickness and accident plan is available. Information about the student insurance plan may be obtained by consulting the SUNY Delhi website at www.delhi.edu, click on Quick Links and then click on Health Services.

It is the policy of Counseling and Health Services that student medical records are confidential. No information is released without written authorization of the student except in some emergency or public health situations or under a court-ordered subpoena.

CONSENT OF PARENT OR GUARDIAN FOR MEDICAL OR EMERGENCY TREATMENT

I, _____, pursuant to the authority vested in me as
(Name of parent or guardian)

_____ of _____, do hereby
("parent" or "guardian") (name of student)

authorize a practicing physician or nurse practitioner to exercise, for me and on my behalf, all my rights and duties with reference to consenting to appropriate medical, surgical or hospital treatment deemed necessary for the medical or emergency care of my child.

I further authorize vaccination for measles, mumps and/or rubella by Counseling and Health Services if necessary to comply with Public Health law 2165. If necessary, I also authorize the PPD (mantoux skin test for tuberculosis) to comply with Counseling and Health Services health form requirements.

Date of student's birth _____
(month/day/year)

Signed _____ Date _____
(Signature of parent or guardian)