WAGNER COLLEGE

Please circle Programs you are involved in:

Undergraduate, Athlete, P.A. Student, Nursing, 2nd Degree Nursing, International Student, Transfer Student

Center for Health and Wellness
One Campus Road
Staten Island, NY 10301
Phone: (718)390-3158
Fax: (718)420-4170

Health Form DUE: July 1st

For Office Use Only

Utilities----------

CARS----------

Incomplete------

Complete---------

Entered By--------

HEALTH RECORD

Please complete pages 1 & 2, and review the information with your health care provider prior to your physical exam.

LAST NAME (PRINT) FIRST NAME MIDDLE DOB ID#

HOME ADDRESS (NUMBER AND STREET) CITY OR TOWN STATE ZIP CODE

(AREA CODE)HOME TEL. NUMBER (AREA CODE) CELL NUMBER

EMERGENCY CONTACT: NAME/RELATIONSHIP (AREA CODE) CELL NUMBER

EMERGENCY CONTACT HOME ADDRESS (AREA CODE) HOME TEL. NUMBER

LIST OF ALL COLLEGES YOU HAVE ATTENDED AND DATES CITIZENSHIP

SEMESTER/YEAR ENTERING_____

FAMILY HISTORY					Have any of your relatives had any of the following?			
	State of Health	Occupation	Age at Death	Cause of Death		YES	NO	Relationship
Father					Tuberculosis			
Mother					Diabetes			
					Kidney Disease			
Brothers					Heart Disease			
					Arthritis			
					Stomach Disease			
Sisters					Asthma, Hay Fever			
					Epilepsy, Seizures			
					Cancer			

PERSONAL HISTORY:

HAVE YOU HAD?	YES	NO	HAVE YOU HAD?	YES	NO
ADD/ADHD			High Blood Pressure		
Anemia			Inflammatory Bowel Disease		
Anxiety Disorder			Join Injury		
Asthma			Kidney/Bladder Infection		
Back Problems			Menstrual Disorder		
Cancer			Migraines/Headaches		
Chicken Pox			Mitral Valve Prolapse		
Depression			Mononucleosis		
Diabetes			Pneumonia		
Ear Problems/Hearing Loss			Recurrent Strep Throat		
Eating Disorder			Seizure Disorder		
Eye Problems/Vision Loss			Sexually Transmitted Disease		
Head Injury with unconsciousness			Sickle Cell/Sickle Cell Trait		
Heart Murmur			Sinusitis		

PROVIDE COMMENTS ON ALL "YES" ANSWERS IN SPACE BELOW:

_____
_____
_____
_____

PLEASE COMPLETE THE FOLLOWING: Hospitalizations or Operations (give dates & procedures)

_____
_____

Serious Injuries (including fractures, motor vehicle accidents, etc.)

_____
_____

Counseling for Emotional Disorders/Psychiatric Treatment/Drug or Alcohol Rehabilitation

_____

_____

Allergies (medications, food, environment; i.e., insects, chemicals ,animals)

_____
_____

ALL Medications: _____

Tobacco use/amount: _____

Alcohol use/amount: _____

THE INFORMATION I HAVE PROVIDED IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

_____

STUDENT SIGNATURE DATE

_____

PARENT SIGNATURE (if student is under 18 years of age) DATE

I hereby give consent for treatment and immunizations by the Wagner College Health Staff_____
I give permission to discuss my illness with my parents/guardian_____
(To be signed by student and parent/guardian if student is under 18 years of age)

Please send a copy of (1) your health insurance card (front and back) and (2) your prescription card

Please indicate which LAB you utilize: Quest_____ Lab Corp_____

STUDENT IMMUNIZATION RECORD: MUST BE SUBMITTED PRIOR TO CLASS REGISTRATION

Name: _____DOB_____ID#_____

This form must be completed in its entirety, complying with the guidelines specified for each disease.
Please ensure that your physician completes the form as written.

ALL INFORMATION MUST BE IN ENGLISH

*This requirement is in compliance with NYS Public Health Law, Section 2165 MONTH/DAY/YEAR

A. *MMR (Measles, Mumps, Rubella) if given instead of individual immunizations **(required)**

1. Dose 1 - Immunized at 12 months after birth or later …….._____/____/_____
2. Dose 2 - Immunized at least 30 days after 1st dose…….._____/____/_____

B. *Measles (Rubeola) Check appropriate boxes **(required)**

1. Born before 1957 and therefore considered immune……YES ☐ NO ☐
2. Had the disease. Confirmed by physician record…….._____/_____/_____
3. Attached copy of original lab test titer with values …… Specify date of titer _____/_____/_____

Please Note: Physician Assistant and Nursing Students must submit copy of original Lab Titer values for MMR, Varicella & HepB.

4. Dose 1 – Immunized after 1/1/1968 with live measles vaccine
   At 12 mo. after birth or later…….._____/_____/_____
5. Dose 2 – Immunized after 1/1/ 1968 with live measles vaccine
   At least 30 days after 1st dose…….._____/_____/_____

C. Tetanus – Diphtheria immunizations **(required)**

1. Completed primary set of tetanus – diphtheria- pertussis…….._____/_____/_____
2. Date of (Tdap) booster within the last 10 years_____/_____/_____

TO BE COMPLETED AND SIGNED BY STUDENT (OR PARENT/GUARDIAN FOR STUDENT UNDER THE AGE OF 18)
*This requirement is in compliance with NYS Public Health Law Section 2167

D. ***MENINGOCOCCAL TETRAVALENT**(One dose within 5 years) **(required)**
(A,C,Y,W-135/One dose – for college freshmen living in dormitories/residence halls, persons with terminal complement deficiencies or asplenia, laboratory personnel with exposure to aerosolized meningococci, and travelers to hyperendemic or endemic areas of the world. Non-freshmen college students may choose to be vaccinated to reduce their risk of meningococcal disease.)
CHECK ONE (1) BOX ONLY

☐ Meningococcal vaccine Name and date of vaccine: _____

☐ I have read page 8, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided I(my child) will **not** obtain immunization against meningococcal meningitis disease.

Signed_____ Date_____
Student/Parent (if student is under 18)

E. Hepatitis B vaccine: (All college and health sciences students. Three doses of vaccine or two doses of adult vaccine in adolescents 11-15 years of age, or a positive hepatitis B surface antibody with lab report meets the requirement.)

Dose #1_____/_____/_____ Dose #2 _____/_____/_____ Dose #3_____/_____/_____
Adult formulation___Child formulation____ Adult form.____Child form.___ Adult form.____Child form.___

F. Varicella --- #1_____/_____/_____ #2_____/_____/_____ or History of Disease YES ☐ No ☐
or Varicella Titer/Must submit Lab report

G. Quadrivalent Human Papillomavirus
H.P.V. ---#1_____/_____/_____#2_____/_____/_____ #3_____/_____/_____

H. **Medical Exemption**: Attach report from your licensed medical provider if vaccination is medically contraindicated.
I. **Religious Exemption**: Attach documentation from Religious Affiliate

ALL STUDENTS ARE REQUIRED TO HAVE 1 TUBERCULIN SKIN TEST UPON ADMISSION, PLEASE SEE PAGE 7.
ALL PHYSICIANS ASSISTANT AND NURSING STUDENTS ARE REQUIRED TO HAVE THE 2 STEP TUBERCULIN TEST, PLEASE SEE PAGE 7.
The QuantiFERON*-TB Gold In-Tube (QFT-G) IGRA Lab test is acceptable in place of a Tuberculin skin test (TST).
This is recommended by the CDC for all health care workers and persons previously vaccinated with BCG.

HEALTH CARE PROVIDER SIGNATURE REQUIRED:
Health Care Provider's Signature_____Date_____

PRINT NAME:_____ **Stamp Required**
ADDRESS_____
PHONE#_____FAX#_____

FOR OFFICE USE ONLY

Health Record Complete Medical History Incomplete Consent for Minors Incomplete

Immunizations Incomplete Physical Exam Incomplete Letter Sent Date _____

Reviewed by: _____ Date record complete_____
(RN Signature)

Approved Utility List: _____ Insurance Card rec'd: _____

Entered by: _____

FORM MUST BE COMPLETED BY A NON-PARENTAL HEALTH CARE PROVIDER

REPORT OF PHYSICAL EXAM **DATE OF EXAM_____**

NAME: _____DOB:_____ID #:_____

HEIGHT: _____ WEIGHT: _____

TEMP. _____ PULSE _____ BLOOD PRESSURE _____

VISION: RIGHT 20/_____LEFT 20/_____CORRECTED: RIGHT 20/_____Left 20/_____GLASSES/CONTACTS_____

NORMAL	ABNORMAL	PLEASE CHECK EACH ITEM	PLEASE ITEM NUMBER BEFORE EACH COMMENT
		1. Head, neck, face, scalp	
		2. Nose and sinuses	
		3. Mouth and throat	
		4. Teeth and gingival	
		5. Ears	
		6. Eyes (lids, conjunctiva, pupils, etc.)	
		7. Chest and lungs	
		8. Heart (estimate of cardiac function)	
		9. Vascular system (varicosities)	
		10. Abdomen and Viscera (hernia)	
		11.Inguinal hernia	
		12. Endocrine system	
		13. GU system	
		14. Spine and musculoskeletal	
		15. Upper and lower extremities	
		16. Skin and lymphatic's	
		17. Neurologic	

SPECIAL DIETARY REQUIREMENTS: _____

ALLERGIES: _____

MEDICATIONS: _____

SUMMARY OF ABNORMALITIES, RECOMMENDATIONS, INCLUDING EMOTIONAL STATUS:
(Please let us know if you have any concerns, both physical and emotional, that you would like to share with us)

_____

_____

_____

HEALTH CARE PROVIDER SIGNATURE REQUIRED:

Health Care Provider's Signature_____Date_____

PRINT NAME:_____ **STAMP REQUIRED**

ADDRESS_____

_____

PHONE#_____FAX#_____

TUBERCULOSIS RISK QUESTIONNAIRE

Must be completed by all students and returned to Center for Health and Wellness

Name: _____ _ Country of Birth_____

Last *First* *Middle*

	YES	***NO***
1. Have you **ever** had a positive tuberculosis skin test?	☐	☐
2. Have you been in close contact with anyone who was **sick with** tuberculosis?	☐	☐
3. Have you ever injected drugs or 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?	☐	☐
4. Were you born in one of the countries listed below?	☐	☐
5. Within the past 5 years, have you stayed for more than 3 months in any of the countries listed below?	☐	☐

COUNTRIES WITH HIGH RATES OF TUBERCULOSIS

Afghanistan	Burundi	Djibouti	Guyana	Macedonia,	Namibia	Philippines	Swaziland
Angola	Cambodia	Dominican	Haiti	TFYR	Nepal	Portugal	Syrian Arab
Armenia	Cameroon	Republic	Honduras	Madagascar	New Caledonia	Romania	Republic
Azerbaijan	Cape Verde	Ecuador	India	Malawi	Nicaragua	Russian	Tajikistan
Bahamas	Central African	El Salvador	Indonesia	Malaysia	Niger	Federation	Tanzania, UR
Bahrain	Republic	Equatorial	Iran	Maldives	Nigeria	Rwanda	Thailand
Bangladesh	Chad	Guinea	Kazakhstan	Mali	Niue	Sao Tome &	Togo
Belarus	China	Eritrea	Kenya	Marshall	Northern	Principe	Tokelau
Benin	China, Hong	Estonia	Kiribati	Islands	Marina	Senegal	Turkmenistan
Bhutan	Kong SAR	Ethiopia	Korea, DPR	Mauritania	Islands	Sierra Leone	Uganda
Bolivia	China, Macao	Gabon	Korea, Rep.	Mauritius	Pakistan	Solomon	Ukraine
Bosnia &	SAR	Gambia	Kyrgyzstan	Micronesia	Palau	Islands	Uzbekistan
Herzegovina	Colombia	Georgia	Lao PDR	Moldova, Rep	Panama	Somalia	Vanuatu
Botswana	Comoros	Ghana	Latvia	Mongolia	Papua	South Africa	Viet Nam
Brazil	Congo	Guam	Lesotho	Morocco	New Guinea	Sri Lanka	Yemen
Brunei	Congo, DR	Guatemala	Liberia	Mozambique	Paraguay	Sudan	Zambia
Darussalam	Cote d'Ivoire	Guinea	Lithuania	Myanmar	Peru	Suriname	Zimbabwe
Burkina Faso	Croatia	Guinea-Biss					

HIGH RISK: If the answer to **questions 1, 2, 3, 4 or 5** is **YES**, Wagner College requires that you have a medical evaluation for latent tuberculosis infection. **Your healthcare provider must complete the form on page 7**.

MEDICAL EVALUATION FOR LATENT TUBERCULOSIS INFECTION

(To be completed and signed by a licensed healthcare provider)

Student's Name:_____DOB: ____/_____/_____

Last First Middle ID#_____

THIS FORM MUST BE COMPLETED BY YOUR HEALTHCARE PROVIDER

PLEASE NOTE: If student has had a positive tuberculin skin test in the past, the test should not be repeated. Go to section B below.

ALL STUDENTS ARE REQUIRED TO HAVE ONE TUBERCULIN SKIN TEST UPON ADMISSION.
ALL PHYSICIANS ASSISTANT AND NURSING STUDENTS ARE REQUIRED TO HAVE THE 2 STEP TUBERCULIN SKIN TEST.

A. TUBERCULIN SKIN TEST (*Mantoux test – 0.1 ml of purified protein derivative Tuberculin containing 5 tuberculin units injected intradermally into the volar surface of the forearm.)*

Test must be read by a healthcare provider 48-72 hours after administration.

Result of multiple puncture tests, such as Tine or Mono-Vac, are NOT accepted.

1.Date test administered: _____/_____/_____ Date test read: _____/_____/_____ Result _____mm of induration___+____-
Month Day Year Month Day Year Pos Neg

2.Date test administered: _____/_____/_____ Date test read: _____/_____/_____ Result _____mm of induration___+____-
Month Day Year Month Day Year Pos Neg

B. If Tuberculin Skin Test is POSITIVE, now or by history, the following are required:

1. **Date of positive PPD:** Date: _____/_____/_____
Month Day Year
2. **Chest X-ray:** Required (Attach report, NOT the X-ray) Date_____/_____/_____
Month Day Year

☐ Normal ☐ Abnormal_____
Describe

3. **Clinical Evaluation:**

☐ Normal ☐ Abnormal_____
Describe

4. **Treatment:**

☐ **No** ☐ **Yes**_____
(Drug dose, frequency and dates)

C. The QuantiFERON*-TB Gold In-Tube (QFT-G) IGRA Lab test Attach copy of original results.

HEALTHCARE PROVIDER

Name: (Please Print)_____ **STAMP REQUIRED**

Signature_____

Phone: _____Fax:_____

Meningococcal Vaccine

What you need to know

What is the meningococcal disease?

The meningococcal disease is a serious illness, caused by bacteria. Meningitis is an infection of the brain and spinal cord coverings. Meningococcal disease can also cause blood infections. The meningococcal vaccine can prevent 2 of the 3 important types of meningococcal disease in older children and adults. The vaccine is not effective in preventing all types of the disease. But it does help to protect many people who might become sick if the don't get the vaccine.

Who should get the meningococcal vaccine and when?

Meningococcal vaccine is not routinely recommended for most people. College freshman should receive the shot, especially those who live in dormitories because of the close living arrangements.

Who should not get the vaccine or wait?

People who are mildly ill at the time the shot is scheduled can still get meningococcal vaccine. People with moderate or severe illnesses should usually wait until they recover.

What are the risks from the meningococcal vaccine?

The risk of the meningococcal vaccine causing serious harm, or death is extremely small. Getting the vaccine is much safer than getting the disease.

Mild Problems Include:

- Some people who get meningococcal vaccine have mild side effects, such as redness or pain where the shot was given. These symptoms usually last for 1-2 days.
- A small percentage of people who receive the vaccine develop a fever.