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WAGNER COLLEGE

HEALTH RECORD

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

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) STUDENT CELL NUMBER

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

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					Arthritis			
Mother					Cardiovascular Disease			
Siblings:					Cancer			
					COPD			
					Diabetes			
					Epilepsy			
					Kidney Disease			
					Seizure Disorder			

PERSONAL HISTORY:

HAVE YOU HAD?	YES	NO	HAVE YOU HAD?	YES	NO
ADD/ADHD			Epilepsy/Seizure Disorder		
Allergies/seasonal			Hearing Impaired		
Anemia/Bleeding Disorder			Heart Condition/murmur/MVP		
Anxiety			Hepatitis		
Arthritis			Hypertension		
Asperger's Syndrome			Kidney Disease		
Asthma			Lyme's Disease		
Autoimmune disease			Migraine Headache		
Bipolar Disorder			Mononucleosis		
Cancer			Orthopedic disease/injury/surgery		
Chron's Disease/Colitis/IBS/Peptic Ulcer			Pneumonia		
			Recovery/Alcohol/		
Concussion/Head Injury/Traumatic Brain Injury			Sickle Cell Disease/Trait		
Chronic Disease			Thyroid		
Depression			Tourettte's Syndrome		
Diabetes 1 or 2			Vision Impaired		

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

_____

Provider Contact Information:

_____

Allergies (medications, food, environment, latex , insects, chemicals ,animals)

_____

_____

ALL Medications: _____

Tobacco use/amount/Quit:

_____

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)

STUDENT IMMUNIZATION RECORD: MUST BE SUBMITTED PRIOR TO CLASS REGISTRATION

Name: _____ DOB_____ ID#_____

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 ____/____/_____
4. Dose 1 – Immunized after first birthday with live measles vaccine..... .....____/____/_____
5. Dose 2 – Immunized at least 30 days after 1st .....____/____/_____

after 1/1/ 1958 with live measles vaccine

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

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 QUADRAVALENT**(One dose within 10 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 the CDC vaccine information sheets, 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: 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 Quantitative Titer/Must submit Lab report

G. Quadrivalent Human Papillomavirus

H.P.V. ---#1_____/_____/_____#2_____/_____/_____ #3_____/_____/_____

Recommended Vaccine: age group 16-23 years old

H. Meningitis Serogroup Meningococcal Vaccine (Men B) #1____/____/____ #2____/____/____ #3____/____/____

Medical Exemption: Attach report from your licensed medical provider if vaccination is medically contraindicated.

Religious Exemption: Attach documentation from Religious Affiliate

HEALTH INSURANCE IS MANDATORY FOR ALL FULL TIME STUDENTS THAT PROVIDE COVERAGE IN New York STATE
PLEASE SEND A COPY OF YOUR HEALTH INSURANCE CARD AND YOUR PRESCRIPTION CARD (FRONT & BACK)

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.

MEDICAL EVALUATION FOR LATENT TUBERCULOSIS INFECTION

Student's Name:_____ ID#_____
Last First Middle

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.

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.

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 DATE)

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

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.

VACCINE INFORMATION STATEMENT

Meningococcal ACWY Vaccines—MenACWY and MPSV4: *What You Need to Know*

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de Información Sobre Vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Meningococcal disease is a serious illness caused by a type of bacteria called *Neisseria meningitidis*. It can lead to meningitis (infection of the lining of the brain and spinal cord) and infections of the blood. Meningococcal disease often occurs without warning—even among people who are otherwise healthy.

Meningococcal disease can spread from person to person through close contact (coughing or kissing) or lengthy contact, especially among people living in the same household.

There are at least 12 types of *N. meningitidis*, called "serogroups." Serogroups A, B, C, W, and Y cause most meningococcal disease.

Anyone can get meningococcal disease but certain people are at increased risk, including:

- Infants younger than one year old
- Adolescents and young adults 16 through 23 years old
- People with certain medical conditions that affect the immune system
- Microbiologists who routinely work with isolates of *N. meningitidis*
- People at risk because of an outbreak in their community

Even when it is treated, meningococcal disease kills 10 to 15 infected people out of 100. And of those who survive, about 10 to 20 out of every 100 will suffer disabilities such as hearing loss, brain damage, kidney damage, amputations, nervous system problems, or severe scars from skin grafts.

Meningococcal ACWY vaccines can help prevent meningococcal disease caused by serogroups A, C, W, and Y. A different meningococcal vaccine is available to help protect against serogroup B.

2 Meningococcal ACWY Vaccines

There are two kinds of meningococcal vaccines licensed by the Food and Drug Administration (FDA) for protection against serogroups A, C, W, and Y: meningococcal conjugate vaccine (**MenACWY**) and meningococcal polysaccharide vaccine (**MPSV4**).

Two doses of MenACWY are routinely recommended for adolescents 11 through 18 years old: the first dose at 11 or 12 years old, with a booster dose at age 16. Some adolescents, including those with HIV, should get additional doses. Ask your health care provider for more information.

In addition to routine vaccination for adolescents, MenACWY vaccine is also recommended for certain groups of people:

- People at risk because of a serogroup A, C, W, or Y meningococcal disease outbreak
- Anyone whose spleen is damaged or has been removed
- Anyone with a rare immune system condition called "persistent complement component deficiency"
- Anyone taking a drug called eculizumab (also called Soliris®)
- Microbiologists who routinely work with isolates of *N. meningitidis*
- Anyone traveling to, or living in, a part of the world where meningococcal disease is common, such as parts of Africa
- College freshmen living in dormitories
- U.S. military recruits

Children between 2 and 23 months old, and people with certain medical conditions need multiple doses for adequate protection. Ask your health care provider about the number and timing of doses, and the need for booster doses.

MenACWY is the preferred vaccine for people in these groups who are 2 months through 55 years old, have received MenACWY previously, or anticipate requiring multiple doses.

MPSV4 is recommended for adults older than 55 who anticipate requiring only a single dose (travelers, or during community outbreaks).

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

3 Some people should not get this vaccine

Tell the person who is giving you the vaccine:

- **If you have any severe, life-threatening allergies.**

  If you have ever had a life-threatening allergic reaction after a previous dose of meningococcal ACWY vaccine, or if you have a severe allergy to any part of this vaccine, you should not get this vaccine. Your provider can tell you about the vaccine's ingredients.

- **If you are pregnant or breastfeeding.**

  There is not very much information about the potential risks of this vaccine for a pregnant woman or breastfeeding mother. It should be used during pregnancy only if clearly needed.

If you have a mild illness, such as a cold, you can probably get the vaccine today. If you are moderately or severely ill, you should probably wait until you recover. Your doctor can advise you.

4 Risks of a vaccine reaction

With any medicine, including vaccines, there is a chance of side effects. These are usually mild and go away on their own within a few days, but serious reactions are also possible.

As many as half of the people who get meningococcal ACWY vaccine have **mild problems** following vaccination, such as redness or soreness where the shot was given. If these problems occur, they usually last for 1 or 2 days. They are more common after MenACWY than after MPSV4.

A small percentage of people who receive the vaccine develop a mild fever.

Problems that could happen after any injected vaccine:

- People sometimes faint after a medical procedure, including vaccination. Sitting or lying down for about 15 minutes can help prevent fainting, and injuries caused by a fall. Tell your doctor if you feel dizzy, or have vision changes or ringing in the ears.
- Some people get severe pain in the shoulder and have difficulty moving the arm where a shot was given. This happens very rarely.
- Any medication can cause a severe allergic reaction. Such reactions from a vaccine are very rare, estimated at about 1 in a million doses, and would happen within a few minutes to a few hours after the vaccination.

As with any medicine, there is a very remote chance of a vaccine causing a serious injury or death.

The safety of vaccines is always being monitored. For more information, visit: **www.cdc.gov/vaccinesafety/**

5 What if there is a serious reaction?

What should I look for?

- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or unusual behavior.

  Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness—usually within a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a severe allergic reaction or other emergency that can't wait, call 9-1-1 and get to the nearest hospital. Otherwise, call your doctor.
- Afterward, the reaction should be reported to the "Vaccine Adverse Event Reporting System" (VAERS). Your doctor should file this report, or you can do it yourself through the VAERS web site at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

VAERS does not give medical advice.

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling **1-800-338-2382** or visiting the VICP website at **www.hrsa.gov/vaccinecompensation**. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your health care provider. He or she can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)** or
  - Visit CDC's website at **www.cdc.gov/vaccines**

Vaccine Information Statement
Meningococcal ACWY Vaccines

03/31/2016

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42 U.S.C. § 300aa-26