HEALTH AND COUNSELING SERVICES FALL 2014–SPRING 2015

WELCOME! This is important information regarding your registration. You will not be able to register for classes without following the instructions contained in the Health and Counseling Services section. New York State (NYS) Law requires all college students to produce proof of vaccination or immunity to measles (rubeola), mumps, and rubella (German measles). In addition to the MMR requirement, New York State mandates that colleges must provide information to their students on meningococcal meningitis and transmission thereof; the benefits, risks, and effectiveness of immunization; and the availability and cost of the vaccine. It is also **required** by NYS that response forms be returned to the institution and kept on file.

The response form indicates that the student, parent, or guardian has received and reviewed the information, and that the student has either been immunized within the preceding 10 years, or has opted not to obtain immunization against meningococcal meningitis. **Students not fulfilling this requirement within 30 days are prohibited from remaining enrolled in classes.** Please see the enclosed immunization instructions. In addition to the state immunization requirements, we would like you to know that the Center for Disease Control recommends vaccination against bacterial meningitis for college freshmen who live in dormitories. Please check with your doctor regarding this vaccination.

Pratt Institute is concerned about both the health of our students and the high cost of medical care. Therefore, we require that all students have adequate health insurance. Parents, if you are waiving the Pratt Student Health Insurance, please be sure that your insurance plan provides coverage in the New York City area. Give the student an insurance card or a copy of the card and review with him/her how to use the insurance if he/she needs to see a physician or obtain medication. Information regarding Pratt's student health insurance is available online at www.pratt.edu/health and will be mailed to all new and incoming students.

If you have a chronic condition, we have some recommendations to help make your career at Pratt successful. First, you may wish to consider enrolling in the Pratt Student Health Insurance Program in addition to your current insurance if it does not provide adequate coverage in New York. Second, you should let the Health and Counseling Services staff know about your condition in advance. We are available to provide for students' physical and mental health needs through primary care services. In order to best do so, we need accurate and complete health information. Therefore, you will need to have a complete physical exam prior to beginning your studies at Pratt. Finally, please make sure that the form is fully completed and signed. Pratt's Health and Counseling Services welcomes the opportunity to assist students in maintaining their optimal health status.

We wish you a happy and healthy experience at Pratt. For more information about Health and Counseling Services, visit Pratt's website at www.pratt.edu/health. If you have further questions, you may email us at health@pratt.edu or use the contact information below.

Health and Counseling Services
Pratt Institute
215 Willoughby Avenue, Suite 117
Brooklyn, NY 11205
Telephone: 718.399.4542
Fax: 718.399.4544
Email: health@pratt.edu

Please return the Health Evaluation Form, along with the rest of the admissions forms, to the Admissions Office in the pre-addressed envelope provided, by June 15 for fall entrance and by January 1 for spring entrance. We strongly encourage students to keep copies of any submitted forms for future reference.

Pratt

INSURANCE WAIVER INFORMATION FALL 2014–SPRING 2015

The information listed below is subject to change. Please visit www.pratt.edu/health to check for updates.

STUDENT HEALTH INSURANCE PLAN

Important Information

Pratt Institute requires all registered full-time and part-time students to carry adequate health insurance. Student health insurance is offered by Pratt Institute, and all registered students are automatically charged a student health insurance fee. Half of the annual fee will appear as a line item charge on your fall semester account, and the balance will appear on your spring semester account. Students who are currently insured under family or private medical insurance may waive (opt out of) the Student Health Insurance Plan, thus removing the student health insurance fee from their account. Registered students who are in need of health insurance may enroll in the Student Health Insurance Plan.

Instructions and reminders about the student health insurance waiver/enrollment process will be mailed to new students. Email reminders are sent to all registered students as well. This process must be completed by the end of the add/drop period each semester. A waiver is only valid for the semester in which it is completed. You must complete an online waiver every semester that you are attending (fall and spring semester) if you wish to opt out of the Student Health Insurance Plan.

We work diligently with Pratt Institute's Student Health Insurance Plan administrators, Aetna Student Health, to offer a medical insurance program specifically designed for Pratt students. Our primary objective has always been to offer a plan that contains substantial benefits at a reasonable cost. The plan has been well received by our students who have indicated that—even in the face of medical inflation—their primary concern is that our plan should maintain a high level of benefits. When compared to other colleges in the area, Pratt's Student Health Insurance Plan provides one of the highest benefit packages at the lowest cost.

Please remember that some family insurance plans terminate coverage for some dependents, and some HMO plans will not provide coverage outside of the HMO network. Please review your current plan to make sure you have adequate coverage.

If you have questions about benefits provided by the Student Insurance Plan, please contact Aetna Student Health customer service at 866.618.0028 or visit them at aetnastudenthealth.com.

FOR INTERNATIONAL STUDENTS ONLY

If you wish to keep your own medical insurance and your policy is an international insurance policy, it must meet the current policy guidelines below:

- **Minimum $50,000 sickness coverage**
- **Minimum $50,000 accident coverage**
- **Minimum $10,000 repatriation coverage**

IMMUNIZATION INSTRUCTIONS FALL 2014–SPRING 2015

Forms should be received in the Health and Counseling office no later than June 15, 2014 for the fall semester or January 1, 2015 for the spring semester.

A. Measles, Mumps, Rubella

For purposes of the college immunization law, proof of immunity for measles, mumps, and rubella shall mean the following.

Measles:

1. TWO doses of live measles vaccine given on or after the first birthday, at least 30 days apart; OR
2. Physician-documented history of the disease; OR
3. Have blood tested as serological evidence of immunity (titer level).

Mumps:

1. One dose of live mumps vaccine given on or after the first birthday; OR
2. Physician-documented history of the disease; OR
3. Have blood tested as serological evidence of immunity (titer level).

Rubella (German Measles):

1. One dose of live vaccine given on or after the first birthday; OR
2. Have blood tested as serological evidence of immunity (titer level).

Note: Physician-documented history of this disease is not acceptable as proof of immunity. You can obtain documentation regarding your childhood immunizations from any of your previous health care providers (e.g. pediatrician, health clinic, high school nurse) or from your immunization record card, which is generally kept by a parent. You may receive subsequent vaccinations from your private physician or at the city Department of Health.

Note: If you cannot obtain documentation regarding your childhood immunizations, there are several options.

1) Obtain one MMR (measles, mumps, rubella) vaccination, wait one month, and have blood drawn as serological evidence of immunity to measles; OR

2) Obtain two MMR vaccinations one month apart; OR

3) Have blood tested as evidence of serological immunity to measles, mumps, and rubella. However, if the blood test does not document immunity then immunization is necessary.

Exemptions will be granted to individuals born before January 1, 1957, or to individuals with documented medical or religious (according to New York State Law) contradictions to vaccination. Please complete Certificate of Exemption Form for review.

B. Meningococcal Meningitis

Certain college students are at increased risk for meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis. In fact, freshmen living in residence halls are found to have a six-fold increased risk for the disease. A U.S. health advisory panel recommends that college students, particularly freshmen living in residence halls, learn more about meningitis and vaccination.

What is meningococcal meningitis?

Meningitis is spread through the air via respiratory secretions or close contact with an infected person. This can include coughing, sneezing, kissing, or sharing items like utensils, cigarettes, and drinking glasses.

What are the symptoms?

Symptoms of meningococcal meningitis often resemble those of the flu and can include high fever, severe headache, stiff neck, rash, nausea, vomiting, lethargy, and confusion.

Who is at risk?

Certain college students, particularly freshmen who live in dormitories or residence halls, have been found to have an increased risk for meningococcal meningitis. Other undergraduates can also consider vaccination to reduce their risk for the disease.

Can meningitis be prevented?

Yes. A safe and effective vaccine is available to protect against four (4) of the five (5) most common strains of the disease. The vaccine provides protection for approximately three (3) to five (5) years. As with any vaccine, vaccination against meningitis may not protect 100 percent of all susceptible individuals. For more information or to learn more about meningitis or other age-appropriate vaccines and screenings, visit the following websites.

Pratt Institute Health and Counseling Services

www.pratt.edu/student_life/student_services/health_counseling/

Centers for Disease Control and Prevention (CDC)

www.cdc.gov/ncidod/dbmd/diseaseinfo

The American College Health Association

www.acha.org

New York State Department of Health

http://www.health.ny.gov/prevention/immunization/handbook/index.htm

Please Note

While it is not required to be vaccinated against meningococcal meningitis, it is recommended, particularly for those students living in the residences. It is required by NYS, however, that all college students be informed regarding the risks of meningitis and the benefits of vaccination (see next page), and either report the date of their vaccine or defer the vaccine but acknowledge that the information has been provided.

HEALTH EVALUATION FORM FALL 2014–SPRING 2015

Forms should be received by the Health and Counseling office no later than June 15, 2014 for fall entrance or January 1, 2015 for spring entrance.

Please complete this form carefully with your physician, and mail it in with the immunization form in the envelope provided. The information supplied is part of your health record; it will be held in STRICT CONFIDENCE at the Office of Health and Counseling Services. This will not affect your academic standing at the Institute.

First Name: .... Last Name: .... Middle Initial: ....

Date of Birth (mm/dd/yy) .... Sex: ○ M ○ F

Date of Entrance: ○ Spring ○ Summer ○ Fall

Pratt ID Number or Social Security Number ....

Home Address: ....

City: .... State: .... ZIP: .... Country: ....

Local/Cell Phone: ....

Emergency Contact (in U.S. if international student):

Name: .... Relationship: ....

Address: ....

City: .... State: .... ZIP: ....

Local/Cell Phone: ....

College students under age 18 must have parent/guardian sign here to authorize emergency treatment):

Emergency Medical Authorization

I, the undersigned parent or legal guardian of ...., do hereby authorize Pratt Institute, on my behalf, to consent to any emergency hospital care or treatment to be rendered to him or her upon the advice of any licensed provider. I agree to be responsible for all necessary charges incurred by any hospitalization or treatment rendered pursuant to this authorization.

Signed: .... Date: ....

HEALTH EVALUATION FORM FALL 2014–SPRING 2015

PART 1: Student Information To be completed by the student (Please Print).

First Name .... Last Name .... Middle Initial ....

Date of Birth (mm/dd/yy) .... Sex: ○ M ○ F

PART 2: Meningococcal Meningitis To be completed and signed by student or parent/guardian for students under the age of 18.

☐ I have read the immunization instructions, and I received the vaccine on: .... / .... / .... (mm/dd/yy)

☐ I have read the immunization instructions, and I will not receive the vaccine.

.... / .... / .... (mm/dd/yy)

STUDENT'S SIGNATURE (PARENT'S SIGNATURE FOR STUDENTS UNDER 18 YRS.)

PART 3: Recommended Vaccines To be completed by a health-care provider.

1. Last Tetanus Diphtheria booster

.... / .... / .... (mm/dd/yy)

2. Completed primary series of Polio Vaccine

.... / .... / .... (mm/dd/yy)

3. Hepatitis A Vaccine

Date 1: .... / .... / .... (mm/dd/yy)

Date 2: .... / .... / .... (mm/dd/yy)

4. Hepatitis B Vaccine

Date 1: .... / .... / .... (mm/dd/yy)

Date 2: .... / .... / .... (mm/dd/yy)

Date 3: .... / .... / .... (mm/dd/yy)

5. Chickenpox (Varicella) Vaccine

Date 1: .... / .... / .... (mm/dd/yy)

Date 2: .... / .... / .... (mm/dd/yy)

6. HPV Vaccine

Date 1: .... / .... / .... (mm/dd/yy)

Date 2: .... / .... / .... (mm/dd/yy)

Date 3: .... / .... / .... (mm/dd/yy)

PART 4: MMR History To be completed by a health-care provider.

MMR (measles, mumps, rubella): Given as a combined dose instead of individual immunizations

☐ **Dose 1:** Immunized with live vaccine on or after 1 year of age: .... / .... / .... (mm/dd/yy)

☐ **Dose 2:** Immunized at least 30 days after 1st dose .... / .... / .... (mm/dd/yy)

OR

Live Individual Vaccines

☐ **Measles Dose 1:** Immunized with live vaccine on or after 1 year of age .... / .... / .... (mm/dd/yy)

☐ **Measles Dose 2:** Immunized at least 30 days after first dose .... / .... / .... (mm/dd/yy)

☐ **Mumps:** Immunized with live vaccine on or after 1 year of age .... / .... / .... (mm/dd/yy)

☐ **Rubella:** Immunized with live vaccine on or after 1 year of age .... / .... / .... (mm/dd/yy)

OR

Titer : (blood test) showing positive immunity (Dated laboratory results **MUST BE ATTACHED**)

☐ **Measles, Mumps, Rubella** .... / .... / .... (mm/dd/yy)

PART 5: TB (Tuberculosis) Screening Required To be completed by a health care provider.

1. Does the student have signs or symptoms of active TB?

☐ **YES.** Proceed with additional evaluation to exclude active TB disease, including tuberculin skin testing, chest X-ray, and sputum evaluation as indicated.

☐ **NO.** Proceed to question 2.

2. Is the student a member of a high-risk group*?

☐ **NO.** Stop, no further evaluation at this time.

☐ **YES.** Perform TB Skin Test or IGRA blood test. A history of BCG vaccination does not preclude testing of a member of a high-risk group.

See for details: http://www.acha.org/Publications/docs/ACHA_Tuberculosis_Screening_Apr2011.pdf.

Date Placed: .... / .... / .... (mm/dd/yy)

Date Read: .... / .... / .... (mm/dd/yy)

Result: .... **X** .... **MM;** If no induration write "0".

Interpretation (based on mm of induration as well as risk factors)

☐ Positive ☐ Negative

IGRA Results: ☐ Positive ☐ Negative ☐ Indeterminate

If TB skin test is positive or there is a history of a past positive PPD, a chest X-ray is required.

Result: ☐ Normal ☐ Abnormal

Date of X-ray: .... / .... / .... (mm/dd/yy)

Dates of treatment, including medication dose and frequency:

....

....

MANDATORY MEDICAL PROVIDER INFORMATION

Name: .... **MD/NP/PA Phone Number:** ....

Address: ....

SIGNATURE OF MEDICAL PROVIDER: .... **DATE:** ....

STUDENT NAME........................

FAMILY HISTORY Which relative (grandparents, parents, or siblings) has (had) the following:

Cancer (type):	Heart Disease (type):	Mental Disorders:
Tuberculosis:	Substance Abuse:	Other Hereditary Disease:
Diabetes:	Kidney Disease:	
Hepatitis (type):	High Blood Pressure:	

PERSONAL HISTORY Please check if you have ever had or presently have the following:

Blood Disorders:
- ○ Anemia
- ○ Bleeding Disorder
- ○ Blood Clots
- ○ Sickle Cell Anemia/ Trait/Thalassemia

Bone and Joint Problems:
- ○ Arthritis
- ○ Back Problems
- ○ Fractures

Cancer:
- ○ Breast Cancer
- ○ Leukemia/Lymphoma
- ○ Melanoma

Disability:
- ○ Hearing Impairment
- ○ Learning Disability
- ○ Mobility Impairment/ Wheelchair Use
- ○ Vision Impairment

Endocrine:
- ○ Diabetes
- ○ Thyroid Disorder

Stomach/Gastrointestinal:
- ○ Ulcers/Acid Reflux/GERD
- ○ IBS
- ○ Hepatitis
- ○ Hernia

Heart/Cardiovascular:
- ○ High Blood Pressure
- ○ Cholesterol Problems
- ○ Heart Murmur
- ○ Stroke
- ○ Heart Disease

Infections:
- ○ Mononucleosis
- ○ Sexually Transmitted Disease
- ○ HIV+
- ○ Chicken Pox

Mental Health:
- ○ Alcohol/Substance Abuse
- ○ Eating Disorder
- ○ Depression
- ○ ADD/ADHD
- ○ Anxiety Disorder
- ○ Bipolar Disorder
- ○ Self-Injury
- ○ Other

Brain/Neurological:
- ○ Epilepsy/Seizure
- ○ Headaches/Migraines
- ○ Head Injury
- ○ Fainting/Dizzy Spells

Respiratory:
- ○ Asthma
- ○ Chronic Cough
- ○ Hay Fever/Allergies

Skin:
- ○ Acne
- ○ Eczema
- ○ Psoriasis

Social History:
- ○ Smoker (former/current)
- ○ Alcohol Use
- ○ Recreational Drug Use

Urinary:
- ○ Kidney Problems
- ○ Bladder Infections

Women's Health:
- ○ Menstrual Problems
- ○ Polycystic Ovarian Syndrome
- ○ Pregnancy
- ○ Abnormal Pap Smear

Other:

○ **No significant personal medical history.**

Are you allergic to any medications?
○ No ○ Yes

If so, please describe your reaction to such medication:

Do you have any allergies to other substances (e.g. latex, peanuts, etc)?

Describe any major hospitalization or surgery:

Do you have any physical or dietary restrictions?

Do you take any medications regularly (including vitamins)?

STUDENT NAME

HEALTH EVALUATION FORM FALL 2014–SPRING 2015

To be completed by medical provider:

Student Name (First, Last): .... Sex: ○ M ○ F

Date of Birth (mm/dd/yy): .... Date of Exam: ....

Height: ....ft. .... in. Weight: .... lb. Pulse: ..../min Blood Pressure: ....

Vision: (L) .... (R).......... (Both).......... Corrected: ○ Yes ○ No

Hearing: ....

Please comment on the following:

Skin: ....

HEENT: ....

Lungs/Chest: ....

Breasts: ....

Heart/Vascular: ....

Abdomen: ....

Genitourinary: ....

Pelvic: ....

Muscular/Skeletal: ....

Neurological: ....

Endocrine: ....

Psychiatric: ....

Diagnosis/Treatment/Recommendation: ....

As requested by Pratt Institute, I certify that I have, on this date, examined this student. On the basis of this examination and the student's medical history as furnished to me:

○ The student is cleared to participate in supervised college activities including athletics.

○ The student is cleared WITH RESTRICTIONS to participate in supervised college activities including athletics.

Reason: ....

○ The student is NOT cleared to participate in supervised college activities including athletics.

Reason: ....

If conditions arise after the student is cleared for participation, the provider may rescind the clearance until the problem is resolved.

EXAMINER'S SIGNATURE REQUIRED

Examiner's Name (Print/Stamp): ....

Address: ....

Phone Number: ....

Signature/Title: .... (MD/NP/PA) .... Date: ....