SUNY Cobleskill

Wellness Center

Accredited by the ACCREDITATION ASSOCIATION for AMBULATORY HEALTH CARE, INC.

Health and Immunization Record

Personal Information - to be completed by student

Student Name: ______________________________ DOB: ____________ Gender: [ ]
Last Middle First

800#: __________ Cell Phone No.: (____)__________ Home Phone No.: (____)__________
Area Code Area Code

Permanent Address: ____
Street Apt.

____
City State Zip Country

Student E-mail Address: ____

Parent/Guardian/Emergency Contact: ____
Last First Relationship

Address: ____
Street City State Zip

Phone Numbers: __________ __________ __________
Home Work Cell

Student's Primary Physician: ____
Last First Phone Fax

Address: ____
Street City State Zip

Have you attended SUNY Cobleskill previously? Yes No If yes, last term attended __________

Please note:

- Failure to submit a completed form may result in delays in the receipt of your official class schedule.
- **We encourage you to keep a copy of this form for your records.**
- Information contained in this form is accessible only by SUNY Beard Wellness Center Staff and will **not** be released without the written authorization of the student, or pursuant to a lawfully issued subpoena, per Section 355 of the Education Law.

Please mail or fax all five pages together to:

SUNY Cobleskill Wellness Center
130 Albany Avenue
Cobleskill, NY 12043
Fax: 518-255-5819
Phone: 518-255-5225

For Office Use Only

Completed __________

Entered __________

Card Sent __________

Student Last Name	First Name	ID#	DOB (mm/dd/yy)

Personal Health History – to be completed by student

Please describe your general state of health by placing an 'X' in the appropriate box:

	Yes	No
Do you have any food or drug allergies?	☐	☐
If yes, please describe:		
Are you taking any medication (including but not limited to birth control pills, over-the-counter medications, inhalers, vitamin/mineral supplements, borrowed medicines, and/or herbal remedies)?	☐	☐
If yes, please include medication name, dose, and frequency:		
Do you have, or have you ever had, a drug abuse or drinking problem?	☐	☐
If yes, please describe:		
Have you ever had any operations? If yes, please describe:	☐	☐
Have you ever been hospitalized? If yes, please describe:	☐	☐
Do you have an eating disorder? If yes, please describe:	☐	☐
Are you, or have you been, a victim of physical or emotional abuse?	☐	☐
If yes, please describe:		
Are you currently being treated for any medical conditions?	☐	☐
If yes, please describe:		
Are you currently in counseling and/or being treated for any psychiatric illnesses?	☐	☐

Please check the box next to any of the diseases or conditions you have had:

- ☐ Anemia
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Colitis or Bloody Stools
- ☐ Diabetes
- ☐ Ear Infection or Discharge
- ☐ Epilepsy
- ☐ Eczema
- ☐ Hay Fever
- ☐ Headaches
- ☐ Heart Problems/Murmur
- ☐ Hepatitis B or C
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Hives
- ☐ Infectious Jaundice/Hepatitis A
- ☐ Kidney Disease
- ☐ Malaria (Yellow Jaundice)
- ☐ Measles
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Paralysis
- ☐ Pneumonia
- ☐ Poliomyelitis
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Rubella
- ☐ Scarlet Fever
- ☐ Severe Injuries
- ☐ Sexually Transmitted Infections
- ☐ Sinusitis
- ☐ Speech Deficit
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis (or positive TB test)
- ☐ Whooping Cough
- ☐ Other: ______________________

Family History

	Mother	Father	Sibling	Sibling	Sibling	Sibling
General State of Health (Good, Fair, Poor, Deceased)						
Age (present or at time of death)						
History of: (place an 'X' in any applicable boxes)						
Tuberculosis	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○
Kidney Disease	○	○	○	○	○	○
Heart Disease	○	○	○	○	○	○
Arthritis	○	○	○	○	○	○
Gastrointestinal Diseases	○	○	○	○	○	○
High Blood Pressure	○	○	○	○	○	○
High Cholesterol	○	○	○	○	○	○

Student Last Name	First Name	ID#	DOB (mm/dd/yy)

Required Immunizations - to be completed by a licensed medical provider

This Information is required by all students enrolled in six credits or more.

MMR: Two doses are required. Dose 1 given on or after 1 year old; dose 2 given no sooner than 28 days after the first dose: exempt if born before 1/1/57

MMR# 1	MMR# 2		Measles# 1	Measles# 2	Mumps:	Rubella:
		OR				
mm/dd/yy	mm/dd/yy		mm/dd/yy	mm/dd/yy	mm/dd/yy	mm/dd/yy

	Measles titer (copy required):	Mumps titer (copy required):	Rubella Titer (copy required):
OR			
	mm/dd/yy	mm/dd/yy	mm/dd/yy

DPT

Within the last 10 years.

Date series complete:		TD booster		Tdap
	AND		OR	
mm/dd/yy		mm/dd/yy		mm/dd/yy

Meningococccal Meningitis Within the last 5 years.

Menomune		Menactra		I have read the Meningitis information found at *www.cobleskill.edu/campus-life/wellness-center*. I decline immunization at this time.
	OR		OR	
mm/dd/yy		mm/dd/yy		Signature required: Student (if age 18 or older) Parent (if student is under 18)

Optional Immunizations & Physical Exam – to be completed by a licensed medical provider
* Hepatitis B required by Paramedic Program

Hepatitis B #1	Hepatitis B #2	Hepatitis B #3	Varicella #1	Varicella #2	Gardasil #1	Gardasil #2	Gardasil #3
mm/dd/yy	mm/dd/yy	mm/dd/yy	mm/dd/yy	mm/dd/yy	mm/dd/yy	mm/dd/yy	mm/dd/yy

Physical Examination: required for participation in college sports and the Paramedic program, otherwise strongly encouraged

Gender ☐ Male ☐ Female

Height: ______________________

Weight: ______________________

B/P: ______________________

☐ This student may participate in all sporting activities.

Date of exam: ________________

Normal/ Abnormal			Comments
		HEENT	
		Teeth and Gingiva	
		Lungs, Chest and Breasts	
		Cardiovascular	
		Abdomen	
		Ano-Rectal	
		Endocrine System	
		Musculoskeletal	
		Neurologic	
		Psychiatric (specify deviations)	
		Pelvic Exam (optional)	

The immunization information on this page requires the signature of a licensed medical provider. A photocopy of a high school immunization record or other certified immunization document is acceptable.

Medical Provider Stamp	Provider Signature	Fax #	License #
Student Last Name	First Name	ID#	DOB (mm/dd/yy)

Tuberculosis (TB) Screening Questionnaire - to be completed by all students

Please answer the following questions:

Are you participating in the Paramedic program? A TB test is **required** for participation. ☐ Yes ☐ No

Have you ever had a positive TB skin test? ☐ Yes ☐ No

Have you ever had close contact with anyone that was sick with TB? ☐ Yes ☐ No

Were you born in one of the countries listed on page 5 and arrived in the United States within the past 5 years? ☐ Yes ☐ No

(If yes, please indicate the country): ______

Have you ever traveled to/in one or more of the countries listed on page 5? ☐ Yes ☐ No

If yes, which ones? ______

If you have answered **yes** to any of the above questions, a health care provider must complete the tuberculosis risk assessment below. If no, further testing is not required.

Tuberculosis (TB) Risk Assessment – to be completed by a licensed medical provider

Recent close contact with someone with infectious TB disease	☐ Yes	☐ No
Foreign–born from (or travel to/in) a high-prevalence area (e.g., Africa, Asia, Eastern Europe, or Central or South America)	☐ Yes	☐ No
Fibrotic changes on a prior chest x-ray suggesting inactive or past TB disease	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
Organ transplant recipient	☐ Yes	☐ No
Immunosuppressed (equivalent of > 15 mg/day of prednisone for > 1 month or TNF - a antagonist)	☐ Yes	☐ No
History of illicit drug use	☐ Yes	☐ No
Resident, employee, or volunteer in a high-risk congregate setting (e.g., correctional facilities, nursing homes, homeless shelters, hospitals, and other health care facilities)	☐ Yes	☐ No
Medical condition associated with increased risk of progressing to TB disease if infected [e.g., diabetes mellitus, silicosis, head, neck, or lung cancer, hematologic or reticuloendothelial disease such as hodgkin's disease or leukemia, end stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (i.e., 10% or more below ideal for the given population)]	☐ Yes	☐ No

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

If no, proceed to 2 or 3. If yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated. ☐ Yes ☐ No

2. Tuberculin Skin Test – required for participation in the Paramedic program three months prior to start of program

Date Given: ______ mm/dd/yy Date Read: ______ mm/dd/yy Result: ______ mm of induration Positive ☐ Negative ☐ Interpretation

3. Interferon Gamma Release Assay (IGRA)

Date Obtained: ______ mm/dd/yy Specify method: QFT-G T-Spot Other: ______

Result: negative ☐ positive ☐ indeterminate ☐ borderline ☐ (T-Spot only)

4. Chest x-ray: (required if TST or IGRA is positive)

Date of chest x-ray ______ mm/dd/yy Result: normal ☐ abnormal ☐

Medical Provider Stamp | Provider Signature | License # | Fax #

Student Last Name ______ First Name ______ ID# ______ DOB (mm/dd/yy) ______

Countries

Afghanistan
Algeria
Angola
Argentina
Armenia
Azerbaijan
Bahrain
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cambodia
Cameroon
Cape Verde
Central African Republic
Chad
China
Colombia
Comoros
Congo
Cook Islands
Côte d'Ivoire
Croatia
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
French Polynesia
Gabon
Gambia
Georgia
Ghana
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Japan
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libyan Arab Jamahiriya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Micronesia (Federated States of)
Mongolia
Montenegro
Morocco
Mozambique
Myanmar
Namibia
Nepal
Nicaragua
Niger
Nigeria
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Saint Vincent and the Grenadines
Sao Tome and Principe
Senegal
Serbia
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
Sri Lanka
Sudan
Suriname
Swaziland
Syrian Arab Republic
Tajikistan
Thailand
The former Yugoslav Republic of Macedonia
Timor-Leste
Togo
Tonga
Trinidad and Tobago
Tunisia
Turkey
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

Suny Cobleskill
Waiver Form

Student Health Insurance Plan

The Accident & Sickness Insurance policy is designed to meet the needs of students at a reasonable price and will supplement the services available at the Beard Wellness Center. Taking advantage of this offer may compliment the health insurance coverage or managed care you already have. Please consider the following in making your decision about waiving out of this policy:

- **If your current coverage is through an HMO or PPO out of the Cobleskill area, services locally may be limited or may be charged to you at a higher rate. You need to contact your health insurance company to investigate your coverage in the Cobleskill area.**
- Your current insurance may not cover the types of expenses most frequently incurred by college age individuals such as outpatient referrals or may cover them only after a deductible or co-payment, this plan helps cover those expenses.
- Coverage through parents' policies may end on a student's birthday, i.e. ages 19, 23 or 25
- This program provides an important level of coverage in addition to Medicare or Medicaid, if these are your only coverage, allowing greater flexibility and choice in the event of an illness.
- Coverage is available for dependents and/or part-time students by contacting: Beard Wellness Center
- Fall coverage: mid August thru early January. Spring coverage: early January thru mid August.

If, after careful consideration of the above items, you wish to remove the Student Accident & Sickness Insurance premium charge from your semester bill, students must demonstrate that they are covered under another health insurance policy. Complete this waiver form and return it with a copy of your health insurance card, before semester check-in to SUNY Cobleskill Wellness Center, 130 Albany Avenue, Cobleskill, NY 12043 or fax it to 518.255.5819.

I hereby waive participation in the Accident & Sickness Insurance program. I certify that I have comparable coverage as indicated below. I acknowledge that I am legally responsible for any and all medical expenses incurred by myself/spouse/son/daughter while enrolled at SUNY Cobleskill. I understand that it is my responsibility to notify SUNY Cobleskill and to enroll in the Accident & Sickness Insurance Policy should my coverage cease at any point during enrollment at SUNY Cobleskill. A copy of my current health insurance card is attached and may be used in place of the below policy information. **I understand that the Insurance Waiver will not be applied until my Health and Immunization Record is submitted and complete.**

Student Last Name________________________ First Name______________________ MI_____

Student ID#__________________________

Mailing Address___________________________ City, State___________________ Zip________

Name of Insurance__________________________________ Policy #_______________________

Name of Policy Holder________________________ Relationship to Insured_____________________

Signature of Parent/Policy Holder_______________________________ Date__________________
(Required)

Signature of Student______________________________________ Date__________________
(Required)

Information regarding the Accident & Sickness Insurance policy can be found at www.cobleskill.edu/wellness

The Accident & Sickness Insurance policy is a bi-annual policy. Failure to waive out of this policy through the use of this form will result in your being billed for coverage each semester. If you waive out and encounter a loss of other health insurance coverage, it is your responsibility to become enrolled in this policy. You may enroll in the Accident & Sickness Policy at any time during the semester by demonstrating proof of a change in your health insurance coverage. Waiving out of the policy can only occur at the beginning of a semester and should be done before your arrival on campus. You will be billed and responsible for payment if a completed waiver is not submitted prior to semester check-in. No waivers will be accepted later than **September 15th** for fall semester and **February 8th** for spring semester.