Residential Student:

The Health Office welcomes you to residential living. It is our goal in collaboration with Residential Life, Safety, and Security, and the Dean of Students to promote health and wellness in the residential hall.

The Health Report is the foundation of each student’s medical record at the college, and thus a critical element in providing care at the Health Office.

Please be advised the Health Report, including immunization records, needs to be completed and mailed or faxed to the Health Office at least 30 days (July 25) prior to the beginning of the semester.

We appreciate your attention to this important time-sensitive matter, and anticipate receiving these documents by the date requested. Failure to comply will jeopardize your housing assignment.

**Residence Life Health requirements:**

- **Measles, Mumps and Rubella:**
  Required immunizations.
  If religious or medical waiver is requested, documentation is required.
  See attached form.

- **Meningitis Vaccine:**
  Highly recommended.
  If you decline, a signed waiver must be on file.
  See attached form.

- **Proof of Health Insurance:**
  All students who live in the residential hall are encouraged to have health insurance.
  All registered students will have an accident insurance policy included in tuition.

- **Health history form.**
  Required.
  See attached form.

Please be sure to include your student ID# (A number) on all forms.

If you need any further assistance, please feel free to contact the Health Office.

Brenda Keller RN, BSN
Supervisor of Nurses
Health Office
Please print or type all information:

ID #: __________________________________________

Name: __________________________________________ Date of Birth: _____________________________

Address: ______________________________________

Cell Phone: __________________ Other Phone: ________________ E-Mail: ________________________

Parent or Guardian: __________________________ Relationship: __________________________

Address: ______________________________________

Cell Phone: __________________ Work Phone: ________________ Home Phone: ______________________

Primary Physician: __________________________ Phone: ______________________________

Address: ______________________________________

Emergency Notification (other than parent or guardian)

Name: __________________ Relationship: ______________________

Home Phone: __________________ Cell Phone: __________________________

Insurance Information:

Carrier: __________________ Phone: ______________ ID #: __________________

To be completed and signed by parent/guardian if student is a minor:

Consent for Medical Care: To the Parents/Guardians of Applicants Under 18 Years of Age Only

In order to acquire any necessary medical care and to protect the clinicians and institutions involved, please sign the consent for medical treatment below. Be assured that we make every effort to notify parents at once in case of major injuries or serious illnesses.

I (print full name), __________________ by the authority vested in me as the parent/guardian of (student’s full name)

__________________________

do hereby authorize the clinical staff at Dutchess Community College’s Health Office to provide routine medical care to my son/daughter. This care may include but not limited to treatment of common illnesses, physical examinations for sport participation, ordering of laboratory tests, and prescribing of medications. Furthermore, I do hereby authorize the staff of Dutchess Community College to seek emergency medical care if necessary.

Signed ____________________________ Date: __________________________
Please print or type all information:

Name: _____________________________    ID # __________________________

Medical History: Check box if history of this condition exists in student:

<table>
<thead>
<tr>
<th>Infectious Disease</th>
<th>Chronic Medical Disorders</th>
<th>Neurologic/Psychiatric Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Chicken Pox</td>
<td>□ Anemia</td>
<td>□ Alcohol/Drug Addiction</td>
</tr>
<tr>
<td>□ Frequent Respiratory Infections</td>
<td>□ Arthritis</td>
<td>□ Anxiety</td>
</tr>
<tr>
<td>□ HIV/AIDS</td>
<td>□ Asthma</td>
<td>□ Attention Deficit Disorder</td>
</tr>
<tr>
<td>□ Malaria</td>
<td>□ Blood Pressure</td>
<td>□ Depression</td>
</tr>
<tr>
<td>□ Mononucleosis</td>
<td>□ Chronic Intestinal/Stomach Problem</td>
<td>□ Eating Disorder</td>
</tr>
<tr>
<td>□ Pneumonia</td>
<td>□ Diabetes</td>
<td>□ Emotional Disorder</td>
</tr>
<tr>
<td>□ Positive TB Skin test</td>
<td>□ Heart Disease</td>
<td>□ Fainting</td>
</tr>
<tr>
<td>□ Sexually Transmitted Infections</td>
<td>□ Kidney Disease</td>
<td>□ Head Injury/ Concussion</td>
</tr>
<tr>
<td></td>
<td>□ Muscular Disorders</td>
<td>□ Hearing Deficit</td>
</tr>
<tr>
<td></td>
<td>□ Orthopedic Problems</td>
<td>□ Migraines</td>
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<tr>
<td></td>
<td>□ Respiratory</td>
<td>□ Speech Deficit</td>
</tr>
<tr>
<td></td>
<td>□ Seizure Disorder</td>
<td>□ Visual Deficit</td>
</tr>
<tr>
<td></td>
<td>□ Sickle Cell Disease</td>
<td>□ Other</td>
</tr>
<tr>
<td></td>
<td>□ Sleep Disorders</td>
<td></td>
</tr>
</tbody>
</table>

Severe Injuries: □ Yes □ No Explain: _______________________________________

Operations:   □ Yes □ No Explain: _____________________________________________

Medical problems other than those above and please clarify any positive responses: ________________________________________________________________

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**ALLERGIES:** (an allergy is a skin rash, hives, joint pain, swollen glands, stuffy nose, and/or fever after exposure to something to which you are allergic.)

Do you have allergies? □ Yes □ No

If YES, check items to which you are allergic.

- [ ] Latex
- [ ] Bee Stings
- [ ] Foods
- [ ] Medications
- [ ] Other

Please list: ________________________________________________________________

__________________________________________  __________________________________

Does your allergy cause an anaphylactic reaction? □ Yes □ No

Does your allergy require the use of adrenalin (epipen)? □ Yes □ No

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**MEDICATIONS:**

Do you take any medications on a regular or frequent basis? □ Yes □ No

Do you take any injectable medications? □ Yes □ No

List all medications:

__________________________________________  __________________________________

__________________________________________  __________________________________

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Student Signature ___________________________________________ Date ________________
Immunization/Meningitis Form

Please print or type all information:        RESIDENT

ID#            Date of Birth:               
Name:                                                
Address:      Street       City    State          
Phone Numbers:        House     Cell           

To be completed by Health Care Professional (MD, PA, NP, RN)

<table>
<thead>
<tr>
<th>Immunization/Disease</th>
<th>Vaccine Date</th>
<th>Disease History (Medically Documented)</th>
<th>Titre Date</th>
<th>Titre Result*</th>
<th>Attach all laboratory records</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR</td>
<td>#1 __________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>#2 __________</td>
<td></td>
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</tr>
<tr>
<td>MEASLES</td>
<td>#1 __________</td>
<td></td>
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<td></td>
<td>#2 __________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MUMPS</td>
<td>#1 __________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RUBELLA</td>
<td>#1 __________</td>
<td>History of Disease Not acceptable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MENACTRA/ MENOMUNE</td>
<td>#1 __________</td>
<td>History of Disease Not acceptable</td>
<td></td>
<td>Titer not acceptable</td>
<td>Titer not acceptable</td>
</tr>
</tbody>
</table>

*All equivocal results require an additional vaccine.

Provider Name: ________________________________ Provider Stamp: ________________________________
Provider Signature: ________________________________
Phone Number: ________________________________

MENINGITIS RESPONSE (complete by student/parent for minor)

Check appropriate box and sign below

I have/my child has:

☐ Had the meningococcal meningitis immunization within the past 10 years. DATE RECEIVED____________________

☐ Read (see enclosed), or have had explained to me, the information regarding meningococcal meningitis disease. I (my child) understand the risks of not receiving the vaccine. I have decided that I (my child) will not obtain immunization against meningococcal meningitis disease.

Student Signature ________________________________ Parent Signature ________________________________
Menactra™, will probably not require booster doses. Menomune™, the older vaccine, requires booster doses every 3 to 5 years. Although research is still pending, the new vaccine, Menactra™, will probably not require booster doses.

What is the duration of protection from the vaccine?
High fever, headache, vomiting, stiff neck and a rash are symptoms of meningococcal disease. The symptoms may appear 2 to 10 days after exposure, but usually within 5 days. Among people who develop meningococcal disease, 10-15% die, in spite of treatment with antibiotics. Of those who live, permanent brain damage, hearing loss, kidney failure, loss of arms or legs, or chronic nervous system problems can occur.

What is the treatment for meningococcal disease?
Antibiotics, such as penicillin G or ceftriaxone, can be used to treat people with meningococcal disease. Should people who have been in contact with a diagnosed case of meningococcal meningitis disease be treated? Antibiotics, such as rifampin, ciprofloxacin or ceftriaxone can be used to treat people with meningococcal disease. The symptoms may appear 2 to 10 days after exposure, but usually within 5 days. Among people who develop meningococcal disease, 10-15% die, in spite of treatment with antibiotics. Of those who live, permanent brain damage, hearing loss, kidney failure, loss of arms or legs, or chronic nervous system problems can occur. Who gets meningococcal disease?
Meningococcal disease is a severe bacterial infection of the bloodstream or meninges (a thin lining covering the brain and spinal cord) caused by the meningococcus germ.

How is the meningococcus germ spread?
The meningococcus germ is spread by direct close contact with nose or throat discharges of an infected person.

What are the symptoms?
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In February 2005, the CDC recommended a new vaccine, known as Menactra™, for use to prevent meningococcal disease in people 11-55 years of age. The previously licensed version of this vaccine, Menomune™, is available for children 2-10 years old and adults older than 55 years. Both vaccines are 85% to 100% effective in preventing the 4 kinds of the meningococcus germ (types A, C, Y, W-135). These 4 types cause about 70% of the disease in the United States. Because the vaccines do not include type B, which accounts for about one-third of cases in adolescents, they do not prevent all cases of meningococcal disease.

Both vaccines are currently available and both are safe and effective vaccines. However, both vaccines may cause mild and infrequent side effects, such as redness and pain at the injection site lasting up to two days. Who should get the meningococcal vaccine?
The vaccine is recommended for all adolescents entering middle school (11-12 years old) and high school (15 years old), and all first year college students living in dormitories. However, the vaccine will benefit all teenagers and young adults in the United States. Also at increased risk are people with terminal complement deficiencies or asplenia, some laboratory workers and travelers to endemic areas of the world. What is the duration of protection from the vaccine?
Menomune™, the older vaccine, requires booster doses every 3 to 5 years. Although research is still pending, the new vaccine, Menactra™, will probably not require booster doses.

How do I get more information about meningococcal disease and vaccination?
Contact your physician or your student health service. Additional information is also available on the websites of the New York State Department of Health; the Centers for Disease Control and Prevention; and the American College Health Association.