**SCHOOL OF ARTS & SCIENCES**

**HEALTH ASSESSMENT FORM**

**PART I** To be completed by applicant

**Seminster:**  
**SSN#:**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Age:</th>
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<tbody>
<tr>
<td>(First)</td>
<td>(M.I.)</td>
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</tbody>
</table>

**Home Address:**

(Number and Street)  
(City)  
(State)  
(Zip)

**Email Address:**

Cell Phone (Self):  
Business Phone (Self):

Parent or Guardian or Spouse:  
Home Phone:

Business Phone (Father):  
Business Phone (Mother):

**Health Insurance Company and Policy #:**

or Medicaid #:

*(Please provide a copy of the insurance card, front and back)*

**HEALTH HISTORY** *(Complete in its entirety)*

Allergies to medications, food, and other substances. *(Include specific reaction.)*

If none, so state:

Place one check (✔) in the appropriate column that corresponds to each item below. If “yes,” provide details and dates:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Convulsive Disorder</td>
<td></td>
<td></td>
<td>Skin Rashes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td>High Blood Pressure</td>
<td></td>
<td></td>
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<tr>
<td>Emotional Problems</td>
<td></td>
<td></td>
<td>Kidney Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headaches</td>
<td></td>
<td></td>
<td>Anemia</td>
<td></td>
<td></td>
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<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td>Tuberculosis+/PPD</td>
<td></td>
<td></td>
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<tr>
<td>Problems with Alcohol</td>
<td></td>
<td></td>
<td>Eating Disorder</td>
<td></td>
<td></td>
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<tr>
<td>Depression</td>
<td></td>
<td></td>
<td>Hepatitis</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chicken Pox</td>
<td></td>
<td></td>
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<tr>
<td>Frequent Diarrhea</td>
<td></td>
<td></td>
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<tr>
<td>Shortness of Breath</td>
<td></td>
<td></td>
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<tr>
<td>Recent Weight Loss/Gain</td>
<td></td>
<td></td>
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<tr>
<td>Smoke Cigarettes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Night Sweats</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Disease</td>
<td></td>
<td></td>
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</tbody>
</table>

Details and dates:

Provide history of any medical conditions and/or surgical procedures:

State medications taken routinely, including medication taken on a daily basis. If none, so state:

☐ I affirm the health history and above information are complete and accurate.

**Student Signature:**  
**Date:** M D Y Y Y Y
PART II—AUTHORIZATION FOR EMERGENCY TREATMENT

The undersigned represents that (student’s name) ________________________________ does not suffer any physical or mental condition requiring any special consideration, therapy or treatment that has not been made known in a letter addressed to The College of New Rochelle Office of Counseling and Health Services.

It is understood that while the College makes an effort to secure quality emergency medical care for the student, the College, its trustees, officers, employees or agents are not responsible for any harm to the student which results from the negligence of third parties in providing such care.

It is understood that the College will attempt to communicate immediately with the student’s parent or guardian to inform them of emergency measures. However, such communication is not pre-condition to the permission and authorization hereby above extended to the authorities of The College of New Rochelle.

Date: ___________ ___________ ___________ ___________ 

Signature: ___________________________ OR Signature: ___________________________ 

(Parent or Guardian) (Student 18 years or older)

IMMUNIZATION RECORD

PART III—STRONGLY RECOMMENDED (All information must be in English) 
To be completed and signed by a health care provider (Dates must include Month, Day, Year)

VARICELLA VACCINE (Please check (✓) only one below)

☐ 1. Had disease; confirmed by office record ___________ ___________ ___________ ___________ 

☐ 2. Immunized with vaccine. Two doses required.

    Dose #1 Date Immunized: ___________ ___________ ___________ ___________ 

    Dose #2 Date Immunized: ___________ ___________ ___________ ___________ (30 days after first dose)

HEPATITIS A (Please check (✓) only one below)

☐ 1. Immunization (Hepatitis A)

    Dose #1 ___________ ___________ ___________ ___________ Dose #2 ___________ ___________ ___________ ___________ 

☐ 2. Immunization (Combined Hepatitis A and B Vaccine)

    Dose #1 ___________ ___________ ___________ ___________ Dose #2 ___________ ___________ ___________ ___________ Dose #3 ___________ ___________ ___________ ___________ 

SEASONAL FLU VACCINE (Please check (✓) only one below)

☐ Intranasal ☐ IM ___________ ___________ ___________ ___________ ___________ ___________ ___________ 

PART IV—THIS NOTICE IS REQUIRED BY PUBLIC HEALTH LAW § 2167

MENINGITIS To be completed and signed by student or parent/guardian if student is under the age of 18

MENINGOCOCCAL (One dose within 10 years recommended by NYS PHL § 2167)
Please complete by checking (✓) only one box and signing.

☐ Had the meningococcal (Menomune™) vaccine within the past 10 years ___________ ___________ ___________ ___________ 

(Revaccinate every 3–5 years if increased risk continues.)

☐ Had the meningococcal (Menactra™) vaccine ___________ ___________ ___________ ___________ 

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

Signature: ___________________________ Date: ___________ ___________ ___________ ___________ 

(Student or Parent/Guardian)
IMMUNIZATION RECORD CONTINUED…

To be completed and signed by a health care provider

TETANUS, DIPHTHERIA, PERTUSSIS (Tdap)

1. Completed primary series of four doses with DTaP, DTP, DT or TD
   (Please check (✓) only one below)

   □ 2. Booster: Tdap (preferred) to replace a single dose of Td for booster immunization at least 2–5 years since last dose of Td, depending on age of patient

   □ 3. Booster: Td within the last ten years

POLO

1. Completed primary series of polio immunizations

   □ Yes  □ No

   Dose #1
   Dose #2
   Dose #3
   Dose #4

MMR (MEASLES, MUMPS, RUBELLA) (If given instead of individual immunizations)

1. Dose #1 — Immunized on or after first birthday

2. Dose #2 — Immunized 28 days after 1st dose

MEASLES (RUBEOLA) (Please check (✓) only one below)

□ 1. Had disease; confirmed by office record

□ 2. Immunized with measles vaccine. Two doses required.

Dose #1 — Immunized on or after first birthday
Dose #2 — Immunized 28 days after 1st dose

□ 3. Has report of immune titer.* Specify date of titer.

MUMPS (Please check (✓) only one below)

□ 1. Had disease; confirmed by office record

□ 2. Immunized with vaccine on or after first birthday

□ 3. Has report of immune titer.* Specify date of titer.

GERMAN MEASLES (RUBELLA) (Please check (✓) only one below)

□ 1. Immunized with vaccine on or after first birthday

□ 2. Has report of immune titer.* Specify date of titer.

Note: Physician diagnosis of Rubella is not acceptable proof of immunity.

HEPATITIS B VACCINE — MUST RECEIVE ALL THREE DOSES

1. Dose #1

2. Dose #2 — Immunized 30 days after the 1st dose

3. Dose #3 — Immunized 6–12 months after the 2nd dose

*The College of New Rochelle Office of Counseling and Health Services provides all required titers and vaccines at student discount prices.
PART V—TO BE COMPLETED BY HEALTH CARE PROVIDER BASED ON EXAM WITHIN THE PAST 12 MONTHS

CBC

URINALYSIS

TUBERCULOSIS SKIN TESTING — (Please check (✔) one only. SEE ATTACHMENT FIRST.)

1. TST within the past 12 months. Give date and test results.

2. Positive TST—Chest x-ray required. Give date and result of chest x-ray.

With (+) TST was patient treated? If so: when, how long, and with what?

With (+) TST—A repeat chest x-ray is required if symptoms of persistent cough, weight loss, and night sweats have been present for the last three months.

3. Had BCG vaccine—Chest x-ray required if TST not done or if TST positive.

PHYSICAL EXAM

Based on physical examination and medical history, the health care provider finds the above student free from health impairments which can carry potential risks to patients and personnel, and might interfere with required duties.

Health Care Provider:

(Print) (Signature)

Address:

License #: Phone #: Date: [ ] [ ] [ ] [ ]

(Required)
1. Does the student have signs or symptoms of active tuberculosis disease? ☐ ☐ ☐
If yes, proceed with additional evaluation to exclude tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

2. Tuberculin Skin Test (TST) (TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write “0”. The TST interpretation should be based on mm of induration as well as risk factors.)**

   Date Given: M D Y Y Y Y Y
   Date Read: M D Y Y Y Y Y
   Result: _____ mm of induration
   **Interpretation: ☐ Positive ☐ Negative

3. Chest x-ray (Required if TST is positive.) Submit documentation.

   Date of chest x-ray: M D Y Y Y Y Y
   Result: ☐ Normal ☐ Abnormal

4. Treatment for Latent Tuberculosis Bacterial Infection (LTBI) Medication: ________________________________

   Date Started: M D Y Y Y Y Y
   Date Completed: M D Y Y Y Y Y
   Date Declined: M D Y Y Y Y Y

5. Include Interferon Gamma Release Assay (IGRA) results, if applicable.

   Physician Signature: __________________________ Date: M D Y Y Y Y Y
   License Number: __________________________ Phone #: __________________________

**INTERPRETATION GUIDELINES

>5 mm is positive:
   Recent close contact with an individual with infectious TB
   Persons with fibrotic changes on a prior chest x-ray consistent with past TB disease
   Organ transplant recipients
   Immunosuppressed persons: taking > 15 mg/d of prednisone for > 1 month; taking a TNF-a antagonist
   Persons with HIV/AIDS

>10 mm is positive:
   Persons born in a high prevalence country or who resided in one for a significant amount of time
   History of illicit drug use
   Mycobacteriology laboratory personnel
   History of resident, worker, or volunteer in high-risk congregate setting
   Persons with the following clinical conditions: silicosis, diabetes mellitus, chronic renal failure, leukemias and lymphomas;
   head, neck, or lung cancer; low body weight (>10% below ideal); gastrectomy or intestinal bypass; chronic malabsorption syndromes

>15 mm is positive:
   Persons with no known risk factors for TB disease
Students who answer YES to any of the following Screening Risk Factors must receive a Mantoux tuberculin skin test (TST) unless a previous positive test has been documented (documentation MUST be included). The test is to be performed within 12 months of entrance to the College. If you answer NO to all of the Screening Risk Factors questions, no further testing is required.

**SCREENING RISK FACTORS**

1. Recent close contact with someone with infectious TB disease  
2. Foreign-born from (or travel to/in) a high-prevalence area  
   (e.g., Africa, Asia, Eastern Europe, or Central or South America)  
3. Prior chest x-ray suggesting inactive or past TB disease  
4. HIV/AIDS  
5. Organ transplant recipient  
6. Recently taken steroids (prednisone) or immunosuppressive drugs  
7. History of illicit drug use  
8. Resident, employee, or volunteer in a high-risk congregate setting (e.g., correctional facilities, nursing homes, homeless shelters, hospitals, and other health care facilities)  
9. Medical condition associated with increased risk of progressing to TB disease if infected  
   (e.g., diabetes, cancer, Hodgkin’s disease, Leukemia, intestinal bypass, or gastrectomy)

**IMPORTANT NOTICE**

If you answered NO to all of the above, sign form and submit to the Office of Counseling and Health Services. If you answered YES, a Tuberculin Skin Test (TST) is required.

Signature: ____________________________  
Date: ___________ ___________ ___________  
(Required)