

## Mohawk Valley Community College Health Information Form

(Page 1 of 7)

Dear Student:

Welcome to Mohawk Valley Community College. The Student Health Center is ready to assist you in any way we can, but first we need important information from you. NYS Public Health Law 2165 requires us to obtain your immunization records. Please read this letter in its entirety and we will be happy to answer any questions you may have.

### Who needs to complete this form?

- **ALL FULL TIME STUDENTS** must complete Parts II, IV, V, VI, and VII of the attached form.
- **PART – TIME STUDENTS** taking 6 or more credit hours must complete Parts II, IV, V, VI, and VII.
- **ATHLETES** must complete Parts II, III, IV, V, VI and VII.
- **ALL HEALTH SERVICES MAJORS WHICH INCLUDE NURSING, MEDICAL ASSISTING/ASSISTANT, RESPIRATORY CARE STUDENTS, HEALTH INFORMATION TECHNOLOGY AND ALLIED HEALTH** must complete Parts II, III, IV, V, VI, VII and VIII. This is an annual requirement for students in these curricula who are registered for off campus clinical courses.
- **INTERNATIONAL STUDENTS** must complete Parts II, IV, V, VI, VII and any other part that applies based on age, activity and curriculum.

### What exactly do the records need to document in order for me to comply with Public Health Law 2165?

- **MEASLES:** (Rubeola)-two (2) doses of LIVE measles vaccine: The first given no more than four (4) days prior to your first birthday. The second given 28 days or more after the first, **OR** physician documentation of the disease **OR** blood test evidence of the immunity (**Serology**). Any documentation for **measles** vaccine **given prior to 1968 must include the words “live vaccine”** or it is not valid.
- **MUMPS:** One (1) LIVE mumps vaccine given no more than four (4) days prior to your first birthday, **OR** physician documentation of the disease, **OR** blood test evidence of immunity (**Serology**).
- **RUBELLA:** (German Measles)-one (1) LIVE rubella vaccine given four (4) days prior to your first birthday, **OR** blood test evidence of immunity (**Serology**). Having had the disease does not prove immunity and will not be accepted. **NOTE:** All Health Services majors must have proof of a **positive titer** in **numerical** form for **rubella prior to entering any clinical site.**

### Where do I obtain an acceptable record of immunization?

- **Your high school** immunization records may assist you in meeting part or all of the immunization requirements. Please obtain a signed copy from your high school nurse and attach it to this form.
- **Your own health records:** Your health care provider may copy the immunization information onto our form and sign the form for verification or they may attach an **official** health office copy.
- **Your local Health Department:** If you received your immunizations at your county Health Department, you can request an official copy from them and attach it to our form.
- **If you are transferring from another college:** You can obtain a copy of your records from that college by contacting their Health Center. You will have to sign an authorization so you should call ahead. They may fax it to us at 315-731-5854.

### Where do I turn in these required records if I'm on campus?

- **MVCC Student Health Center, Alumni College Center Room 104 OR**
- **Rome Campus Student Service Center, Plumley Complex L33**

### Please note:

- Athletes should provide a copy of PART III to their coach.
- The **original** Health Information Form must be mailed to the Attention of the Student Health Center.
- Health Services students must provide a copy of this document to the Health Services Department secretaries no later than 2 weeks prior to the start of classes.

Please do not hesitate to contact the office for further clarification. Your diligence and thorough completion of this document will enable us to serve you better as you begin your studies at MVCC.

Sincerely,  
Student Health Center Staff

**Exemptions**

*MVCC recognizes medical and religious exemptions as defined by New York State Public Health Law 2165.*

**Medical Exemptions:**

- *If a licensed physician, nurse practitioner or licensed physician assistant certifies in writing that a student has a health condition which is a valid contraindication in receiving the required immunizations, a medical exemption will be granted for the amount of time the physician recommends (whether it is temporary or permanent).*
- *Temporary exemptions will be reviewed and the student will be notified of the need to comply once the exemption is no longer valid.*

**Religious Exemptions**

- *Requests for a sincere and genuine religious exemption must be in writing and should include significant information that explains how the practice of immunization is contrary to the student’s religious beliefs.*
- *MVCC does not challenge a person’s personal religious convictions. New York State does not recognize philosophical views as a religious exemption; therefore, MVCC does not as well.*
- *In the event of an outbreak, those students with medical and religious exemptions will be excluded from campus and classes to protect them from exposure for as long as they could be at risk.*

**Internet Exemption**

- *MVCC reserves the right to make exemptions to on-line students who are taking 6 or more credit hours and who are not required to be on campus in any group setting, such as quizzes, tests, finals, projects, etc. Non-presence on campus must be verified in writing by each instructor.*

**PART I – FOR STUDENTS UNDER 18 YEARS OF AGE ONLY**

**TO: *Parents and guardians of students under 18 years of age***

To avoid delay in treatment interventions, you are encouraged to sign the authorization below for medical or emergency treatment and return the form to the Student Health Center at MVCC. This consent for treatment applies only to care given by the Student Health Center. The student may be referred off campus for further treatment.

**Consent of Parent for Medical or Emergency Treatment**

I, \_\_\_\_\_, pursuant to the authority invested in me as  
\_\_\_\_\_ of \_\_\_\_\_ do hereby authorize a licensed  
(Parent or Guardian) (Student’s Name)

health care professional, under appropriate medical supervision, to exercise for me and on my behalf, all my rights and duties with reference to consenting to appropriate medical, treatment as deemed necessary for the medical or emergency care of my  
\_\_\_\_\_ (Son or Daughter).

Signed: \_\_\_\_\_ Relationship to student: \_\_\_\_\_  
(Signature of Parent or Guardian)

Date: \_\_\_\_\_

Name: \_\_\_\_\_ \*Social Security # \_\_\_\_\_  
(Print Last Name first) (First) (M.I.)

\_\_\_\_\_  
(Home Address-Street) (City) (State) (Zip)

\_\_\_\_\_  
(Other address if different from home address; i.e. dorm address) (City) (State) (Zip)

Home Phone #:(\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_) Utica #:(\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_) Date of Birth: \_\_\_/\_\_\_/\_\_\_ Male \_\_\_ Female \_\_\_

Semester Entering MVCC: Mo. \_\_\_ Yr. \_\_\_ Curriculum: \_\_\_\_\_ Full-time \_\_\_ Part-time \_\_\_

\*Disclosure of Social Security Information is voluntary and is used for student identification. Authority to solicit the Social Security Number has been established under Section 335 of the Education Law of New York State. Any information given is kept strictly confidential.

**PART III – ATHLETES AND STUDENTS ENROLLED IN HEALTH SERVICES MUST HAVE THIS SECTION COMPLETED AFTER JUNE 1<sup>ST</sup> FOR FALL SEMESTER AND AFTER NOVEMBER 1<sup>ST</sup> FOR SPRING SEMESTER. (OPTIONAL BUT HIGHLY RECOMMENDED FOR ALL OTHER STUDENTS TO COMPLETE.)**

**MEDICAL HISTORY:** Please check if you have had any of the following in the past year. If “yes”, give date and explain below.

- Have you been “knocked out” or experienced a concussion? N \_\_\_ Y \_\_\_
  - Have you ever fainted, become lightheaded or get chest pain during exercise? Y \_\_\_ N \_\_\_
  - Have you had an eye injury? Y \_\_\_ N \_\_\_ Contact lenses Y \_\_\_ N \_\_\_
  - Do you have a dental appliance? Y \_\_\_ N \_\_\_
  - Have you had a neck injury? Y \_\_\_ N \_\_\_
  - Have you had a shoulder injury? Y \_\_\_ N \_\_\_
  - Have you had an elbow injury? Y \_\_\_ N \_\_\_
  - Have you had a back or spinal injury? Y \_\_\_ N \_\_\_
  - Have you had a kidney injury or blood in the urine? Y \_\_\_ N \_\_\_ Any kidney disease Y \_\_\_ N \_\_\_
  - Have you had a hip injury? Y \_\_\_ N \_\_\_
  - Have you had a knee injury? Y \_\_\_ N \_\_\_
  - Have you experienced a severe sprain of either ankle? Y \_\_\_ N \_\_\_
  - Have you had any broken bones? Y \_\_\_ N \_\_\_
  - Have you suffered any other illness or injury? Y \_\_\_ N \_\_\_ Eating disorder Y \_\_\_ N \_\_\_ Emotional disorder Y \_\_\_ N \_\_\_
  - Have you ever suffered from heat stroke or heat exhaustion? Y \_\_\_ N \_\_\_ Rheumatic fever Y \_\_\_ N \_\_\_
  - Is there a family history of Sudden Cardiac Death? Y \_\_\_ N \_\_\_ Heart murmur Y \_\_\_ N \_\_\_ High blood pressure Y \_\_\_ N \_\_\_
  - Do you have any disabilities, loss of limb/organs? Y \_\_\_ N \_\_\_ Any hearing impairment Y \_\_\_ N \_\_\_
  - Do you suffer from asthma or have a history of asthma? Y \_\_\_ N \_\_\_ Tuberculosis Y \_\_\_ N \_\_\_ Diabetes Y \_\_\_ N \_\_\_ Epilepsy Y \_\_\_ N \_\_\_
- Please explain any “yes” answers above and give dates:
- \_\_\_\_\_
- \_\_\_\_\_

Have you ever had an operation? Y \_\_\_ N \_\_\_ If so, when? \_\_\_\_\_ What? \_\_\_\_\_  
List any medication (including vitamins, supplements) you are taking (how much and how often):

\_\_\_\_\_

List any medical condition you are currently under a doctor’s care for: \_\_\_\_\_  
List any known allergies: \_\_\_\_\_

**PHYSICAL EXAM: to be completed by M.D., D.O., NP, or PA. (Must be completed for students participating in sports and Health Services Majors)**  
Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_ Pulse \_\_\_\_\_ Visual acuity: R \_\_\_ L \_\_\_ (w/o correction) R \_\_\_ L \_\_\_ (with correction)

Heart \_\_\_\_\_

Lungs \_\_\_\_\_

Hernia \_\_\_\_\_ Follow-up recommended? Y \_\_\_ N \_\_\_

Other comments: \_\_\_\_\_

**Health Care Provider: please check below only that which applies to this student.**

\* (Athlete) This student is able to participate in Intercollegiate Athletics: Yes \_\_\_ No \_\_\_ Which Sport(s)? \_\_\_\_\_

\*\* (ALL HEALTH SERVICES STUDENTS) This student is in satisfactory physical condition to care for infant, child, and adult patients in actual hospital/clinical settings. (Please see Essential Functions List in Part VIII of this form.) Yes \_\_\_ No \_\_\_

Health Care Provider’s Name (print) \_\_\_\_\_ Phone # (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_

Health Care Provider’s Signature \_\_\_\_\_ Date: \_\_\_\_\_

**PART IV – IMMUNIZATION RECORD –(READ INSTRUCTIONS ON FIRST PAGE FOR DETAILS IN HOW TO COMPLETE THIS SECTION.) All information must be in English. Completion of the Immunization Record is required of all students enrolled in 6 or more credit hours and born after January 1<sup>st</sup>, 1957. These immunizations are a requirement for continued enrollment in classes.**

| <b>DISEASE</b><br>Immunizations<br>See page 1 | <b>VACCINE DATE</b><br>Shot #1-must be given no more than 4 days prior to first birthday. | <b>VACCINE DATE</b><br>Shot #2-given 28 days or more after #1. | Use month, day, and year for dates. |                             | Physician documentation of having disease.          |
|---|---|--|-------------------------------------|-----------------------------|---|
| <b>MMR</b>                                    |   |  | <b>Serology Date</b>                | <b>Results (Circle one)</b> |   |
| <b>Measles</b>                                |   |  |                                     | +      -                    |   |
| <b>Mumps</b>                                  |   |  |                                     | +      -                    |   |
| <b>Rubella</b>                                |   |  |                                     | +      -                    | <b>Having this disease does not prove immunity.</b> |

**A positive rubella titer of 1.1 or above is mandatory for Health Services majors (even with proof of MMR vaccination).**

**TUBERCULIN TEST IS MANDATORY ANNUALLY FOR ALL STUDENTS IN HEALTH SERVICES MAJORS.**

Foreign students, students in the Hospitality Program, and students living on campus should also be tested.

**TUBERCULIN TEST (Mantoux/PPD is required) Date given** \_\_\_/\_\_\_/\_\_\_ **Date read** \_\_\_/\_\_\_/\_\_\_ **Result:** \_\_\_\_ (Record actual mm. of induration).  
M D Y M D Y

**Chest x-ray required if skin test is positive... Date** (of chest x-ray): \_\_\_/\_\_\_/\_\_\_ ...**Results** (of chest x-ray): Neg.\_\_\_\_ Pos.\_\_\_\_  
M D Y

\*Student with a positive Mantoux/PPD must have a chest x-ray prior to entering health programs and every 2 years.

If chest x-ray is positive, describe length and type of treatment: \_\_\_\_\_.

**Other Immunizations (recommended but not required):**

**A) TETANUS-DIPHTHERIA (Td) booster within the last 10 years..... Date** \_\_\_/\_\_\_/\_\_\_  
M D Y

**B) HEPATITIS B – (Three doses of vaccine or 2 doses of adult vaccine in adolescents 11-15 years of age, or a positive Hepatitis B surface antibody.)**

1. Immunization (Hepatitis B)... **Dose #1** \_\_\_/\_\_\_/\_\_\_ **Dose #2** \_\_\_/\_\_\_/\_\_\_ **Dose #3** \_\_\_/\_\_\_/\_\_\_  
M D Y M D Y M D Y

2. Immunization (Combined Hepatitis A and Hepatitis B) ...**Dose#1** \_\_\_/\_\_\_/\_\_\_ **Dose #2** \_\_\_/\_\_\_/\_\_\_ **Dose #3** \_\_\_/\_\_\_/\_\_\_  
M D Y M D Y M D Y

3. Hepatitis B surface antibody...**Date** \_\_\_/\_\_\_/\_\_\_ **Result:** Reactive\_\_\_\_ Non-reactive\_\_\_\_  
M D Y

**C) VARICELLA (Either a history of chicken pox, a positive Varicella antibody, or 2 doses of vaccine given at least one month apart if immunized at the age of 13 or older, meets the requirement. Titer is required for Nursing, Medical Assisting/Assistant and Respiratory Care students if there is no history of disease.)**

1. History of disease. Yes: \_\_\_ No: \_\_\_\_...(If “Yes”, do not answer #2 & #3.)

2. Varicella antibody \_\_\_/\_\_\_/\_\_\_ Reactive: \_\_\_ Non-reactive:\_\_\_\_  
M D Y

3. Immunization: Dose #1 \_\_\_/\_\_\_/\_\_\_ Dose #2 (given at least 1 month after first dose, if age 13 or older) \_\_\_/\_\_\_/\_\_\_  
M D Y M D Y

**D) MENINGOCOCCAL DISEASE:** Name of vaccine: \_\_\_\_\_ Date of vaccine \_\_\_/\_\_\_/\_\_\_  
M D Y

**Health Care Provider’s Name (Print):** \_\_\_\_\_ **Tel. No. ( ) -** \_\_\_\_\_ - \_\_\_\_\_

**Health Care Provider’s Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Address of Health Care Provider:** \_\_\_\_\_



## Meningococcal Disease

### What is 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.

### Who gets meningococcal disease?

Anyone can get meningococcal disease, but it is more common in infants and children. For some adolescents, such as first year college students living in dormitories, there is an increased risk of meningococcal disease. Every year in the United States approximately 2,500 people are infected and 300 die from the disease.

### 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?

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 be treated?** Only people who have been in close contact (household members, intimate contacts, health care personnel performing mouth-to-mouth resuscitation, day care center playmates, etc.) need to be considered for preventive treatment. Such people are usually advised to obtain a prescription for a special antibiotic (rifampin, ciprofloxacin or ceftriaxone) from their physician. Casual contact, as might occur in a regular classroom, office or factory setting, is not usually significant enough to cause concern.

### Is there a vaccine to prevent meningococcal meningitis?

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.

### Are the vaccines safe? Are there adverse side effects to the vaccine?

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 family physician or your student health service. Additional information is also available on the websites of the New York State Department of Health, [www.health.state.ny.us](http://www.health.state.ny.us); the Centers for Disease Control and Prevention [www.cdc.gov/ncid/dbmd/diseaseinfo](http://www.cdc.gov/ncid/dbmd/diseaseinfo); and the American College Health Association, [www.acha.org](http://www.acha.org).

**PART VIII –MVCC HEALTH SERVICES DEPARTMENT ESSENTIAL FUNCTIONS LIST.  
ALL HEALTH SERVICES STUDENTS MUST COMPLETE THIS PART.**

MVCC seeks to provide equal access to its programs, services, and activities for people with disabilities. Therefore, to the extent practicable, the college will endeavor to make a reasonable academic adjustment for an applicant with a disability that is otherwise qualified.

The essential function of a student enrolled in a Health Services curriculum requires that the student, with or without reasonable accommodations, must be able to (if required) do the following:

1. Demonstrate the ability to perform essential function for a maximum of a 10 hour shift.
2. Demonstrate the ability to protect a patient when the patient is standing and ambulating on all surfaces with or without the use of assistive devices, including canes, crutches and walkers.
3. Demonstrate the ability to safely move a patient over 100 pounds from one surface to another using the appropriate level of help.
4. Demonstrate safe body mechanics in the process of all patient treatments, including lifting and carrying equipment (under 50 pounds) and moving large equipment (over 50 pounds).
5. Demonstrate the ability to manipulate dials on equipment.
6. Demonstrate the ability to coordinate simultaneous motions.
7. Demonstrate the ability to perform occasional overhead extension.
8. Demonstrate the ability to hear blood pressure, heart and lung sounds with or without corrective devices.
9. Demonstrate the ability to palpate soft tissue, including pulse, muscle and bones.
10. Demonstrate the ability to perform interventions such as sterile procedures, dressing changes and administer medications (including dosage calculations when necessary) following infection control procedures.
11. Demonstrate adaptability to change in a dynamic health care environment.
12. Demonstrate the ability to establish effective relationships with others.
13. Demonstrate the ability to communicate effectively, safely and efficiently in English by:
  - Explaining procedures.
  - Receiving information from others.
  - Receiving information from written documents.
  - Exhibiting appropriate interpersonal skills.
14. Demonstrate the ability to distinguish color changes.
15. Demonstrate the ability to detect an unsafe environment and carry out appropriate emergency procedures including:
  - A. Detecting subtle environment changes and odors, but not limited to, the smell of burning electrical equipment, smoke and spills.
  - B. Detect high and low frequency sounds, including but not limited to, alarms, bells, and emergency signals.

These are the Essential Functions of the Health Services Department. If there are any reasons why you may not be able to perform these functions with or without reasonable accommodations, you should notify the Department Head or Program Coordinator as soon as possible.

I have read and am aware of the policy regarding Essential Functions. I understand that if there are any reasons that I cannot perform these functions, I must notify the Department Head or Program Coordinator.

Name of Student (Print): \_\_\_\_\_ Date \_\_\_\_\_

Student Signature (or Parent/Guardian Signature if Student is a Minor): \_\_\_\_\_