

SARAH • LAWRENCE • COLLEGE

Dear Incoming Student,

On behalf of the staff of Sarah Lawrence College Health Services, I would like to extend to you a warm welcome to Sarah Lawrence College.

In order to provide you with the most comprehensive care while you are at Sarah Lawrence College, we *require* the completion of *all* health forms.

**** All forms will be found on the Health Services section of the Sarah Lawrence College Website. To access and download the forms, go directly to:**

<http://www.slc.edu/healthservices/forms/>

It is essential that we have your medical information on file so that we can be aware of your health profile and your particular needs.

In addition, the Physical Assessment-Form B, is required in order to participate in organized sports or to use the SLC Sports Center.

Please use this checklist to assure all required documentation has been reviewed and submitted:

- Submit the Health History- Form A** (requires student completion and signature)
- Submit the Physical Assessment-Form B** (requires physician completion and signature.) If you are unable to obtain a complete physical exam before the deadline, at a minimum you must submit the immunization record with physician signature, or a copy of an official immunization form documenting MMR vaccination according to New York State requirements.(See Sarah Lawrence College Immunization Fact Sheet with downloaded forms). **Failure to submit this documentation will result in your inability to register for classes.**
- Submit the Tuberculosis (TB) Risk Factor Screening** (requires physician signature)
- Submit the Student Consent to Treat / Emergency Card** (requires student completion)
- Read the downloaded Meningococcal Disease Information Sheet**
- Read the downloaded Immunization Fact Sheet**

Again, all required forms must be received no later than **April 30, 2008** for Early Decision Students and **May 30, 2008** for Regular Decision Students. We appreciate your cooperation in returning these forms promptly and look forward to your arrival on campus. Questions can be directed to SLC Health Services at **(914) 395-2350**.

Sincerely,

Dr. Nance Roy
Director, SLC Health Services

STUDENT FORM-SIGNATURE REQUIRED

RETURN FORMS TO:

Sarah Lawrence College Health Service
1 Mead Way, Bronxville, N.Y. 10708
(914) 395-2350 FAX (914) 395-2640
www.sarahlawrence.edu/healthservices

HEALTH ASSESSMENT- FORM A

COMPLETE THIS FORM AND BRING TO YOUR PHYSICIAN TO REVIEW AT THE TIME OF YOUR PHYSICAL EXAM
This information is strictly for the use of the Health Services and will not be released to anyone without your knowledge and consent.

_____	_____	_____	_____
Last name	First name	Middle initial	Date of birth
_____		_____	_____
Street address		City	State Zip Code
_____		_____	_____
e-mail address		home phone	cell phone
_____		_____	_____

I. FAMILY HISTORY

Have any of your relations ever had any of the following?

	Yes	No	relationship		Yes	No	relationship
Cancer	___	___	_____	Intestinal disorder	___	___	_____
Tuberculosis	___	___	_____	Asthma/Hay fever	___	___	_____
Diabetes	___	___	_____	Arthritis	___	___	_____
Kidney Disease	___	___	_____	Psychiatric illness	___	___	_____
Heart Disease	___	___	_____	Epilepsy, Seizures	___	___	_____
Other _____							

II. PERSONAL HISTORY

Have you personally had any of the following?

	Yes	No		Yes	No
Sinusitis	___	___	Chronic cough	___	___
Eye Problems	___	___	Tuberculosis/ + PPD	___	___
Ear, Nose, Throat Problems	___	___	Gallbladder disease	___	___
Recurrent headache/migraine	___	___	Hepatitis/Liver disease	___	___
Head injury/concussion	___	___	Intestinal disorder	___	___
Fainting spells/seizure	___	___	Malignancy/cancer	___	___
ADD /learning disability	___	___	Kidney/bladder disease	___	___
Heart disease/murmur	___	___	Joint disease/injury	___	___
Substance abuse	___	___	Psychiatric/mental health disorder	___	___

If yes, describe: _____

List any surgical procedures:

List all allergies: _____

III. MEDICATIONS:

List all prescription and over-the counter medications taken on a regular basis in the past year

Medication name	Dose	Condition	Current	/	Past
_____	_____	_____	_____		_____
_____	_____	_____	_____		_____
_____	_____	_____	_____		_____
_____	_____	_____	_____		_____

IV. TO BE COMPLETED AND SIGNED BY STUDENT (OR PARENT/GUARDIAN FOR STUDENTS UNDER AGE 18)

Meningococcal Meningitis Vaccine response: I have/ my child has:

- had the meningococcal meningitis immunization within the past 10 years. Type: _____ Date received: ___/___/___
- read the information provided 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: ___/___/___

PHYSICIAN'S FORM-SIGNATURE REQUIRED

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1 Mead Way, Bronxville, N.Y. 10708
(914) 395-2350 fax: (914)395-2640
www.sarahlawrence.edu/healthservices

PHYSICAL ASSESSMENT- FORM B

To the examining Physician: Please review the student's history and complete this form. Please comment on all positive answers. This student has been accepted and the information supplied will not affect his/her status. It will be used for continuity of care and for sports clearance.

_____/_____/_____
Last name First Middle initial Date of birth Gender

BP _____ Urinalysis: LMP _____
Pulse _____ Sugar _____ Hematocrit _____
Height _____ Albumin _____ Corrected Vision R____/____ L____/____
Weight _____ Micro. _____ ALLERGIES _____

Are there abnormalities of the following systems? Describe fully. Use additional sheet if needed.

	Yes	No	Describe
Ears, Nose Throat	_____	_____	_____
Respiratory	_____	_____	_____
Cardiovascular	_____	_____	_____
Gastrointestinal	_____	_____	_____
Hernia	_____	_____	_____
Genitourinary	_____	_____	_____
Muscle tone/strength	_____	_____	_____
Joint Abnormalities	_____	_____	_____
Metabolic/Endocrine	_____	_____	_____
Neurologic	_____	_____	_____
Psychiatric	_____	_____	_____
Dermatologic	_____	_____	_____

Is patient now under treatment for any medical or mental health condition? Yes _____ No _____

If yes, your recommendations _____

Is this patient currently taking prescription medication? List below if yes. Yes _____ No _____

Recommendations for physical activity/intercollegiate activities

Unlimited _____ Limited _____ Explain: _____

IMMUNIZATION FORM *REQUIRED FOR REGISTRATION**

Complete below or attach copy of immunization record

RECOMMENDED IMMUNIZATIONS

***** REQUIRED IMMUNIZATIONS *****

N.Y. State requires documentation of MMR immunity in order to register for college.

Persons born before 1957 are exempt from this requirement.

Tetanus-Diphtheria (last Booster) ___/___/___

OPV ___/___/___

Hep A #1 ___/___/___ #2 ___/___/___

Hep B #1 ___/___/___ #2 ___/___/___ #3 ___/___/___

Varicella ___/___/___ or illness ___/___/___

Meningitis vaccine Type: _____

Date: ___/___/___

MMR #1 given at >1 year of age ___/___/___

MMR #2 given >30 days after dose #1 ___/___/___

OR proof of Measles, Mumps, Rubella immunity by titre:
attach copy of laboratory titre results.

MD / Provider signature: _____ **Date of exam:** _____

Address: _____ **Phone:** _____ **Fax:** _____

Physician's Stamp/Name

STUDENT/PARENT FORM-SIGNATURE REQUIRED

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Student Consent to Treat and Emergency Card

Student's Name _____

DOB ____/____/____ SS# _____

I hereby authorize Sarah Lawrence College to notify my parent or guardian in the event of a serious medical/mental health emergency. It is further understood that I am responsible for notifying my parents or guardians about any non-emergent personal health problems.

For the time I am a student, I hereby authorize Sarah Lawrence College to assume responsibility for my care in the emergency room, and consent to surgery/anesthesia, should such a procedure be deemed an emergency and I am not able to consent. I consent to follow up care after discharge from the emergency room with Sarah Lawrence College Health Services. I understand Health Services will have access to my hospital medical records for the purpose of follow up medical care.

Signature of Student (required): _____ Date: _____

Signature of Parent (if student is under age 18): _____ Date: _____

Emergency Contact Information:

Name _____		Name _____
Address _____	OR	Address _____
_____		_____
Home phone _____		Home phone _____
Cell phone _____		Cell phone _____
Work phone _____		Work phone _____

Is student allergic to any medication? _____

Is there any medical condition we should be aware of in case of an emergency?

Consent for treatment of student under the age of 18:

I hereby grant permission to evaluate, examine and treat what may be considered advisable or necessary in the judgment of the physician/nurse practitioner/nurse/psychologist at Sarah Lawrence College Health Services until the minor's 18th birthday.

Prior to prescribing treatment or referring your child/ward to an outside medical or mental health provider, Health Services staff will make every attempt to contact parent or guardian.

Signature of Parent or Guardian: _____ Date: _____

Sarah Lawrence College Immunization Fact Sheet

Students born on or after January 1, 1957 are required to show proof of immunization before registering.

Immunization requirements:

- **Measles Immunization:**

- Two injections on or after January 1, 1968 (at least 30 days apart) administered on or after the student's first birthday.

Immunizations administered prior to January 1, 1968 are acceptable if there is proof that a live vaccine was used.

- Or provide the date of the physician-documented disease
- Or provide a Positive Immune Titer

- **Mumps Immunization:**

- One injection on or after January 1, 1969 administered on or after the student's first birthday

- Or provide the date of the physician-documented disease
- Or provide a Positive Immune Titer

- **Rubella Immunization:**

- One injection on or after January 1, 1969 administered on or after the student's first birthday

- Or provide a Positive Immune Titer (Proof of disease not acceptable)

- **Meningitis:**

- The student* must indicate one of the following on the Health Assessment - Form A:

- a. That the student has had the meningococcal vaccination within the past ten years or...
- b. An acknowledgement of the meningococcal risks and refusal of the vaccination.

* or parents/guardian of students if student is under the age of 18

Health Services - Meningococcal Disease Information Sheet

Information for College Students and Parents of Children at Residential Schools

York State Department of Health Bureau of Communicable Disease Control

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).

Who gets meningococcal disease?

Anyone can get meningococcal disease, but it is more common in infants and children. For some college students, such as freshmen living in dormitories, there is an increased risk of meningococcal disease. Between 100 and 125 cases of meningococcal disease occur on college campuses every year in the United States; between 5 and 15 college students die each year as result of infection. Currently, no data are available regarding whether children at overnight camps or residential schools are at the same increased risk for disease. However, these children can be in settings similar to college freshmen living in dormitories. Other persons at increased risk include household contacts of a person known to have had this disease, and people traveling to parts of the world where meningitis is prevalent.

How is the germ meningococcus spread?

The meningococcus germ is spread by direct close contact with nose or throat discharges of an infected person. Many people carry this particular germ in their nose and throat without any signs of illness, while others may develop serious symptoms.

What are the symptoms?

High fever, headache, vomiting, stiff neck and a rash are symptoms of meningococcal disease. 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.

How soon do the symptoms appear?

The symptoms may appear two to 10 days after exposure, but usually within five days.

What is the treatment for meningococcal disease?

Antibiotics, such as penicillin G or ceftriaxone, can be used to treat people with meningococcal disease.

Is there a vaccine to prevent meningococcal meningitis?

Yes, a safe and effective vaccine is available. The vaccine is 85% to 100% effective in preventing four kinds of bacteria (serogroups A, C, Y, W-135) that cause about 70% of the disease in the United States. The vaccine is safe, with mild and infrequent side effects, such as redness and pain at the injection site lasting up to 2 days. After vaccination, immunity develops within 7 to 10 days and remains effective for approximately 3 to 5 years. As with any vaccine, vaccination against meningitis may not protect 100% of all susceptible individuals.

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](#), the [Centers for Disease Control and Prevention](#), and the [American College Health Association](#).