ROBERTS WESLEYAN COLLEGE

Dear In-coming Student,

Welcome to Roberts Wesleyan College. As you embark on this new chapter in your life, I would like to take this opportunity to present a synopsis about the health center and provide important information to assist you in completing the attendance requirement.

A healthy college community is vital for student's academic success, and to ensure it, our committed physician assistants, and administrative staff are dedicated to offering high-quality medical and wellness-prevention services to keep students healthy and experience a productive and memorable time at Roberts Wesleyan College.

In satisfying the New York State Public Health Laws prerequisites for college attendance, please complete the attached health history form which comprises of demographics, health background queries, authorization signatures, physical examination, and immunizations formatted forms. If having difficulties locating your immunization records, the reverse side of this letter provides examples of how to obtain the mandated immunization documents.

All international and athlete students, as well as, any students participating in college sponsored overnight or mission's trip are required to carry and supply validation of health insurance coverage by submitting a copy of an ID card with their name on it or a letter of creditable coverage showing the date when the student's coverage began. Whether you are required to have insurance or not, it is suggested for students to carry health insurance.

To maintain confidentially and expedite your submission, please send your documents directly to the Health Center via mail, email to healthcenter@roberts.edu, or fax to 585.594.6920. ***Due to the significant amount of submissions, the recording process may take up to a week***, so it is best to submit your documents as soon as possible. Please note submission deadline is one month before first class session. Remember to make copies for your own personal files.

For more detail information about the health center services, and to download copies of health history forms for full-time undergrad students, nursing students, and student-athletes, please visit our website at www.roberts.edu/healthcenter.

Should you need assistance, please feel free to contact me at 585.594.6360 or email me at Burks_Blandine@roberts.edu. I am more than happy to help you in whatever way possible for you to receive the healthiest college experience possible.

Best Regards,

Blandine P. Burks

Blandine P. Burks
Coordinator, Health Center

New York State Public Health Law (NYSPHL) 2165 & 2167 mandates all students born on or after January 1, 1957, enrolled in six credit hours or more, demonstrate proof of immunity to measles, mumps, rubella, and meningococcal meningitis disease by vaccines or titer test results.

Examples of acceptable documents for immunization and physical:

- Roberts Wesleyan College Health History form completed by a health care provider
- Official copy of medical record from your health care provider
- Official copy of childhood school or high school immunization record
- Official copy of the previous college immunization record
- Official copy of employer health record
- Official copy of military health record

All the above records must present the following:

1. Dates of 2 MMRs vaccines, or TWO measles, one rubella and one mumps vaccines, or titer (blood) test results showing immunity to measles, mumps, and rubella. *(Equivocal, negative or non-immune titer results are not acceptable and vaccination is required)*.
2. The meningococcal meningitis vaccine or Meningococcal Meningitis Vaccination Declination Statement completed and signed by the student if he or she did not receive the meningitis vaccine and elect to waive it at this time.
3. A physical record within a year. Nursing students are required to submit a physical , varicella vaccine, and tuberculin screening and flu vaccine dated within a year. In-coming athletes, MUST have a physical no later an six months prior to the start of sports participation. The Health Center provides physicals, tuberculin screening and flu vaccines.

If you are unable to retrieve any immunizations records there are three alternatives to fulfill the NYSPHL immunization requirements for TWO measles, one mumps and one rubella:

1. Obtain a titer (blood) test for measles, mumps, and rubella
   The titer test with the positive or immune results are acceptable proof
   (Equivocal, negative or non-immune results are NOT acceptable and vaccination is required)
2. Obtain TWO MMR (measles, mumps, rubella) vaccines. MMR vaccines must be obtained at least 28 days or more apart.
3. Obtain one MMR vaccine, then after 28 days obtains a titer (blood) test specific for measles.
   The measles titer test with the positive or immune results are acceptable proof. *(Equivocal, negative or non-immune results are NOT acceptable and vaccination is required)*

Two options for the meningococcal requirement:

1. Obtain one meningococcal meningitis vaccine
2. Sign and date the meningococcal meningitis vaccine declination statement

Please note: History of the rubella disease is not acceptable. Rubella vaccine or rubella titer test with the positive or immune result are acceptable proof.

All students are required to complete the attachd Tuberculin screening form to determine if a tuberculin PPD test is required for attendance.

ROBERTS WESLEYAN COLLEGE

Health/Physical/Immunization Form for College Attendance

New or Transfer Full-time Undergrad Students with 6 credit hours or more

Please check all that apply:	*Failure to comply with the New York State Public Health Law 2165 and 2167 regulations will prevent clearance for attendance.*	**Office Use Only**
Year: 2 _____ ❑ Fall semester ❑ Spring semester ❑ Summer semester ❑ Please list sport(s) _____ ❑ Undergraduate Freshman ❑ Transfer Student ❑ International Student ❑ E.L.I. Student ❑ B.E.L.L. Student	To secure and maintain confidentiality, please submit the completed form and documents directly to the Health Center: 1. Mail to 2301 Westside Drive, Rochester, NY 14624 2. Email at healthcenter@roberts.edu 3. Fax (secured line) at 585-594-6920 Incomplete or unsigned forms will not be processed.	**Received:** _____ **Cleared by:** _____ **Date:** _____ **DEADLINE Date:** One month prior to first class session or sport participation. Early submission will expedite attendance compliance process.

Last name: _____ First: _____ Middle Intial:_____

Date of birth: (MM-DD-YY) ____/____/____ Sex: M ❒ F ❒ Citizenship: U.S. ❒ Other ❒ (specify) _____

Address: (street/PO box) _____

City/Town: _____ State: ____Zip: _____ Home Phone:(____)_____-_____

Cell Phone: (____) _____- _____ Email Address: _____

INSURANCE INFORMATION: Mandatory for athletic, international and nursing students

Last: (Primary) _____ First:_____ Middle Initial: _____

Relationship to student: _____ Primary's DOB: _____/_____/_____ Primary's Gender:_____

Insurance Company:_____

Policy No:_____ Group No:_____

Effective Date: _____/_____/_____ Termination Date: _____/_____/_____

RELEASE OF INFORMATION / EMERGENCY CONTACT:

I give permission to the Health Center staff at Roberts Wesleyan College to discuss my health care with the individual indicated below. I also authorize this person to be called in case of an emergency.

Name: _____ Relationship: _____

Daytime phone #: _____ Evening Phone #: _____ Cell phone #: _____

Student's signature: (required) _____ Date: _____/_____/_____

AUTHORIZATION FOR TREATMENT

In submitting this Health History Form, I attest the information is complete and accurate. I authorize Roberts Wesleyan College Health Center to provide medical treatment and services as they deem appropriate. I understand the information may be shared with the Athletic Department, Campus Security, Counseling Center and/or Learning Center staff as/if needed, in order to facilitate collaboration among campus services for my comprehensive health care.

I understand that my medical records are confidential and maintained separately from my academic records. To have my medical records shared with others requires my written permission except in the event of a life-threatening and/or serious illness or injury of which the Health Center is aware, parents(s) or guardian may be notified at the discretion of the professional staff. *This authorization for treatment is active for the duration I am a student at Roberts Wesleyan College.*

Student's signature: (required) _____ Date: _____/_____/_____

Parent's signature: **(required if student is under age 18)** _____ Date: _____/_____/_____

Family History: To be completed by the student and/or parent/guardian(s)

	Age and state of health		Occupation	Age at death and cause (if applicable)		Have your grandparents/parents/ siblings had any of the following?	Y	N	Relationship
Father						Arthritis			
Mother						Asthma, Seasonal Allergies			
Brother(s)						Cancer			
						Diabetes			
						Epilepsy, Convulsions			
						Heart Disease / Stroke			
Sister(s)						High Blood Pressure			
						Kidney Disease			

General Health: Please give details below for any "yes" answers.

Have you had:	Y	N		Y	N		Y	N		Y	N
ADD/ADHD			Depression			Impaired Vision			Thyroid Disease		
Alcohol/Drug Dependency			Diabetes			Irritable/spastic bowel			Tuberculosis		
Anemia			Disease/Injury of Joints			Kidney Disease			Ulcerative Colitis		
Anger Issues			Seizure disorder (specify below)			Kidney Infection			Urinary Tract Infections		
Anorexia Nervosa			Ear/Nose/Throat Problems			Kidney Stones			Venereal Disease		
Anxiety			Endocrine/Metabolic Disorder			Malaria			Weight Loss/Gain		
Arthritis (specify below)			Fainting			Measles (specify below)			Allergy To:		
Asthma			Fractures (specify below)			Mononucleosis			Penicillin		
Back Problems			Frequent Colds or Sinusitis			Mumps			Sulfonamides		
Bipolar Disorder			Gall Bladder Disease			Orthopedic Problems			Other (specify below)		
Blood Disorders (specify)			Gastrointestinal/GERD/Reflux			Recurrent Headaches			Food (specify below)		
Bulimia			Head Injury (Serious/Unconscious)			Rheumatic Fever					
Cancer			Heart Murmur			Rubella (German Measles)			Surgery:		
Cerebral Palsy			Heart Palpitations			Scarlet Fever			Appendectomy		
Chicken Pox			Hepatitis (specify below)			Seasonal Allergies			Tonsillectomy		
Convulsive Disorder			Hernia			Self-harming Behavior			Wisdom Teeth Removed		
Crohn's Disease			High Blood Cholesterol			Skin Conditions			Other (specify below)		
Cystic Fibrosis			High Blood Pressure			Sleep Disorder			Last Dental Exam Date		
Cystitis/bladder Infection			Impaired Hearing			Suicidal Thought/Attempts					

Explanation(s):

Medical History (Answer all questions)	Yes	No	Explain all "yes" answers below or on an additional sheet and attach.
Do you have any drug/medication allergy?			
Do you smoke?			
Do you consume alcohol?			
Do you use recreational drugs?			
Has your physical activity been restricted during the past five years?			
Have you had any illness or injury or been hospitalized other than already noted above?			
Do you have an ongoing health problem that has required treatment by a physician or other health care provider in the past five years?			
Have you received treatment by a psychiatrist or clinical psychologist?			
Do you take medication on a regular basis? If so, please list name(s) and dosage(s).			
Do you consider yourself challenged or disabled in any way that requires you to receive special consideration from RWC? If so, please specify.			

Examination: *(Physical record must be dated within a year)*

Student Name _____ **Physical Date:** _____/_____/_____

Height: _____ **Weight:** _____ **BP:** _____ **Pulse:** _____ **BMI:** _____ **Vision: L 20/**_____ **R 20/** _____

	No	Yes	Note variances, abnormal or significant findings
General			
HEENT			
Neck/Endocrine			
Respiratory			
Cardiovascular			
Breast			
Abdomen			
Genitourinary			
Hernia			
Neurologic			
Skin			
Musculoskeletal			
Neck/Shoulder/Arm			
Wrist/Hand/Fingers			
Hip/Thigh/Knee			
Leg/Ankle/Foot			

Does the student have drug allergies? If yes, please list by name and type of reaction: _____

_____

Recommendations/Comments regarding the chronic condition or serious illness continuing care of the student:

_____

_____

Recommendations/Comments regarding the emotional, continuing care of the student:

_____

_____

Medically cleared to participate in a full program of college study _____Yes _____ No

Medically cleared for intercollegiate athletic participation _____Yes _____ No

Limitations/Comments: _____

Medical provider signature/stamp or a copy of the medical provider's document must be attached. **STAMP**

_____

MD, NP, or PA's Signature

_____

MD, NP, or PA's Printed Name

_____

Address, City, State

Immunization Record: *(Medical provider's signature/stamp or copy of the record is required)*

Student's Name _____ Date of Birth _____/_____/_____

MANDATED IMMUNIZATIONS AND SCREENING FOR ATTENDANCE

1. NYS Public Health Law 2165 mandates students born after January 1, 1957 enrolled in six (6) credit hours or more provide documented proof of immunity (vaccines or titer (blood) test results against measles, mumps, rubella and meningoccal meningitis disease. **NYS Public Health Law 2167 mandates** ALL students, **regardless of age**, to provide either proof of meningococcal vaccine or signed declination statement rejecting the meningococcal vaccine.

MMR #1 (Measles, Mumps, Rubella) Date: _____/_____/_____

MMR #2 (Measles, Mumps, Rubella) Date: _____/_____/_____

OR documentation of immunity to measles, mumps, and rubella by separate vaccines or (blood) titer tests

Measles 1 (Rubeola) Date: _____/_____/_____ or Positive/Immune Measles Titer Date: _____/_____/_____

Measles 2 (Rubeola) Date: _____/_____/_____ or Positive/Immune Mumps Titer Date: _____/_____/_____

Mumps Date: _____/_____/_____ or Positive/Immune Rubella Titer Date: _____/_____/_____

Rubella (German measles) Date: _____/_____/_____ History of the rubella disease is not acceptable

2. Meningococcal Vaccine Type: _____ Date: _____/_____/_____ *(dated within 5 years)*

Student elected not to be immunized against meningococcal meningitis disease.

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 decided NOT to be immunized against the meningococcal meningitis disease.

Student Signature: _____ Date: _____/_____/_____

3. Tuberculosis Screening ***(Required for international, nursing and high risk students)*** (dated within one year)

PPD (Mantoux) within the past year: Date placed: _____/_____/_____ Date read: _____/_____/_____ (within 48-72 hours)

RESULT: ____ Negative _____ Positive _____ mm indurations *(If positive, chest x-ray report is required)*

RECOMMENDED IMMUNIZATIONS: ***(Hepatitis B, Varicella, and up-to-date Flu vaccine required for nursing students)***

Tetanus/Diphtheria/Pertussis Date: _____/_____/_____ (dated within 10 years) Series completed: yes ____ no ____

Hepatitis B #1 Date: _____/_____/_____ Hepatitis A #1 Date: _____/_____/_____

Hepatitis B #2 Date: _____/_____/_____ Hepatitis A #2 Date: _____/_____/_____

Hepatitis B #3 Date: _____/_____/_____ Hepatitis B Positive Titer Date: _____/_____/_____

Varicella # 1 Date: _____/_____/_____ or Varicella disease Yes ____ No ____ Date: _____/_____/_____

Varicella #2 Date: _____/_____/_____ or Varicella Positive Titer Date: _____/_____/_____

IPV / OPV #1 _____/_____/_____ #2 _____/_____/_____ #3 _____/_____/_____ #4 _____/_____/_____

Polio Booster Date: _____/_____/_____

Flu Vaccine Date: _____/_____/_____ Trivalent (IIV3) ___ Quadrivalent (IIV4) ___ Recombinant(RIV3) ___ Live attenuated (LAIV)___

Medical provider signature/stamp or a copy of the medical provider's document must be attached. **STAMP**

_____

MD, NP, or PA's Signature:

_____

MD, NP, or PA's Printed Name:

_____

Address, City, State:

TUBERCULOSIS SCREENING

Student Name _____ Birthdate _____ / _____ / _____

Please answer the following questions:

1. Have you ever had a positive TB (tuberculin) skin test? Yes _____ No _____
2. Have you been in recent close contact with persons known or suspected to have TB? Yes _____ No _____
3. Were you born in one of the countries listed below and arrived in the U.S. within the past 5 years? (If yes, please circle the country) Yes _____ No _____
4. Have you ever traveled to/in one or more of the countries listed below within the past 5 years? (If yes, please check the country or countries) Yes _____ No _____
5. Have you ever been vaccinated with BCG? Yes _____ No _____
6. Have you been a 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 ____
7. 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 orgastrectomy, chronic malabsorption syndrome, low body Yes _____ No _____
8. Have you ever been a member of any of the following groups that may have an increased incidence of latent *M. tuberculosis* infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol? Yes _____ No _____

If the answer is YES to any of the above questions, Roberts Wesleyan College requires that you have your physician complete the back side of this page to determine if it is necessary to receive TB testing as soon as possible but at least prior to the start of the subsequent semester.

If the answer to all of the above questions is NO, no further testing or further action is required.

* *The significance of the travel exposure should be discussed with a health care provider and evaluated.*

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
China, Hong Kong SAR
China, Macao SAR
Colombia
Comoros
Congo
Côte d'Ivoire
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
Fiji
French Polynesia
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iran (Islamic Republic of)
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia (Federated States of)
Mongolia
Montenegro
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Northern Mariana Islands
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
South Sudan
Sri Lanka
Sudan
Suriname
Swaziland
Tajikistan
Thailand
Timor-Leste
Togo
Trinidad and Tobago
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

TUBERCULOSIS (TB) RISK ASSESSMENT

Student Name _____ Birthdate _____ / _____ / _____

Clinician pleas review and verify the student Tuberculosis screening information. Persons answering YES to any of the questions are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented. Then a copy of the chest x-ray report is required.

History of a positive TB skin test or IGRA blood test? (If yes, document below) **Yes _____ No _____**
History of BCG vaccination? (If yes, consider IGRA) **Yes _____ No _____**

1. TB Symptom Check

Does the student have signs or symptoms of active pulmonary tuberculosis disease? Yes _____ No _____
If No, proceed to 2 or 3

If yes, check below:

- ❑ Cough (especially if lasting for 3 weeks or longer) with or without sputum production
- ❑ Coughing up blood (hemoptysis)
- ❑ Chest pain
- ❑ Loss of appetite
- ❑ Unexplained weight loss
- ❑ Night sweats
- ❑ Fever

Proceed with additional evaluation to exclude active 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: ____/____/____ Date Read: ____/____/____
M D Y M D Y

Result: _____ mm of induration **Interpretation: positive____ negative____

Date Given: ____/____/____ Date Read: ____/____/____
M D Y M D Y

Result: _____ mm of induration **Interpretation: positive____ negative____

****Interpretation guidelines**

>5 mm is positive:

- Recent close contacts of an individual with infectious TB
- persons with fibrotic changes on a prior chest x-ray, consistent with past TB disease
- organ transplant recipients and other immunosuppressed persons (including receiving equivalent of >15 mg/d of prednisone for >1 month.)
- HIV-infected persons

>10 mm is positive:

- recent arrivals to the U.S. (<5 years) from high prevalence areas or who resided in one for a significant* amount of time
- injection drug users
- mycobacteriology laboratory personnel
- residents, employees, or volunteers in high-risk congregate settings

- persons with medical conditions that increase the risk of progression to TB disease including silicosis, diabetes mellitus, chronic renal failure, certain types of cancer (leukemias and lymphomas, cancers of the head, neck, or lung), gastrectomy or jejunoileal bypass and weight loss of at least 10% below ideal body weight.

>15 mm is positive:

- persons with no known risk factors for TB who, except for certain testing programs required by law or regulation, would otherwise not be tested.

** The significance of the travel exposure should be discussed with a health care provider and evaluated.*

3. Interferon Gamma Release Assay (IGRA)

Date Obtained: ____/____/____ (specify method) QFT-GIT T-Spot other_____
M D Y

Result: negative___ positive___ indeterminate___ borderline___ (T-Spot only)

Date Obtained: ____/____/____ (specify method) QFT-GIT T-Spot other_____
M D Y

Result: negative___ positive___ indeterminate___ borderline___ (T-Spot only)

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

Date of chest x-ray: ____/____/____ Result: normal____ abnormal_____
M D Y

Management of Positive TST or IGRA

Students with a positive TST or IGRA with no signs of active disease on chest x-ray should receive a recommendation to be treated for latent TB with appropriate medication. However, students in the following groups are at increased risk of progression from LTBI to TB disease and should be prioritized to begin treatment as soon as possible.

- ❑ Cigarette smokers and persons who abuse drugs and/or alcohol
- ❑ Infected with HIV
- ❑ Recently infected with *M. tuberculosis* (within the past 2 years)
- ❑ History of untreated or inadequately treated TB disease, including persons with fibrotic changes on chest radiograph consistent with prior TB disease
- ❑ Receiving immunosuppressive therapy such as tumor necrosis factor-alpha (TNF) antagonists, systemic corticosteroids equivalent to/greater than 15 mg of prednisone per day, or immunosuppressive drug therapy following organ transplantation
- ❑ Diagnosed with silicosis, diabetes mellitus, chronic renal failure, leukemia, or cancer of the head, neck, or lung
- ❑ Have had a gastrectomy or jejunoileal bypass
- ❑ Weigh less than 90% of their ideal body weight

••Populations defined locally as having an increased incidence of disease due to *M. tuberculosis*, including medically underserved, low-income populations

_____Student agrees to receive treatment

_____Student declines treatment at this time

Medical provider signature/stamp or a copy of the medical provider's document must be attached. **STAMP**

_____
MD, NP, or PA's Signature:

_____
MD, NP, or PA's Printed Name:

_____
Address, City, State: