

ITHACA

Dear Incoming Student:

Welcome to Ithaca College.

Please fill out the attached health certification form carefully and completely, so we may

- protect your health and that of your fellow students
- comply with New York State law
- have a basis for understanding and serving your health needs at the College

Please pay particular attention to pages five and six, where the immunization and test requirements are listed. New York State law is very specific about these requirements, and compliance is strictly enforced. **Students who do not complete the immunization requirements mandated by New York State will be withdrawn from the College.**

To assist you and your health care provider in completing the immunization portion of the form, there is a summary page of instructions on the back of this letter. It is **your** responsibility to submit a fully completed health certification form, so please check to be sure it is complete before sending it to us. Also, it is a good idea to keep a copy of the form and your immunization information for your own records.

Please return the form to us by July 15 for fall admission or one week before the beginning of classes for spring or summer admission. Within two weeks of receiving the form we will notify you if anything is incomplete.

The required immunizations and tests can be administered at Hammond Health Center, here at the College, for a nominal fee, but I encourage you to have these completed prior to coming to Ithaca.

There are only two possibilities for exemption from the immunization requirements: New York State law allows exemption based upon 1) a written and signed statement that the student has sincere and genuine religious beliefs that prohibit immunization or 2) a written statement from a physician or physician extender specifying those immunizations that may be detrimental to the student's health (or otherwise medically contraindicated) and the length of time they may be detrimental. In the case of an outbreak on campus, students who have been granted an exemption will be treated as susceptible and either immunized or excluded from campus.

Students born before January 1, 1957, are exempt from the measles/mumps/rubella requirements but must still complete the tuberculosis assessment.

We want to see you in school, we want to protect your health and that of your classmates, we want to comply with New York State law, and we want to do it at the smallest cost compatible with getting the job done well. Please help us by sending your health form in early and being sure that all the instructions have been followed.

If you have questions, please contact Donna Mistler at 607-274-3286 or dmistler@ithaca.edu.

Sincerely,



David E. Newman, M.D.
Director

REMOVE TOP SHEET ONLY BEFORE MAILING FORM TO ITHACA COLLEGE

**TO THE HEALTH CARE PROVIDER:
INSTRUCTIONS FOR COMPLETING THE IMMUNIZATION INFORMATION
(Pages 5–6 of the Health Certification Form)**

Please complete the form fully. Signatures of the health care provider certify that all information about the immunizations and tests is accurate. **Signatures are required as noted.** The penalty for not providing complete information is severe for the student. If the New York State requirements are not met, the student will be withdrawn from school. N.Y.S. Public Health Law #2165 requires that all full-time students born on or after 1/1/57 be immunized against measles, mumps, and rubella. If the immunization information is not provided with adherence to the details required by the state, we cannot accept it.

NOTE: All submissions must be in English. If information is certified on a separate attached document, that information must be copied onto our form.

- **TUBERCULIN SKIN TEST:** All entering students must complete the tuberculosis assessment, on page 5, and undergo PPD testing if indicated.

NEW YORK STATE REQUIREMENTS INCLUDE

- **MEASLES:** Students must receive **two** shots of live virus vaccine, with the first one given *no earlier than* four days before their first birthday **and** both given *on or after* 1/1/68. Shots given before 1968 will not be accepted unless an affidavit (or copy of record) is attached to this form, stating, “Live virus vaccine was given without simultaneous administration of immune globulin.” The two shots must be given at least 28 days apart. You must give the month/day/year for each shot, **and** a signature is required on the line to the right of **each** date. This date can be certified by physician/nurse signature **or** by copy of official documents certifying what injections were given and when. (NOTE: Students may also meet this requirement by providing a copy of a lab report demonstrating their protective antibody titer. Documented history of the disease is acceptable **only** if it is physician-documented and if the physician’s signature is on the line to the right of this selection.)
- **MUMPS and RUBELLA:** Students must receive a single dose of each *on or after* 1/1/68 **and no earlier than** four days prior to their first birthday. The month/day/year must be provided and certification must be provided on the line to the right of the date. As with the measles vaccination, this requirement can be met by providing a copy of a lab report demonstrating the student’s protective antibody titer or a physician-documented and certified history of disease.
- **NOTE:** A second measles shot is still needed if the MMR vaccine is the only vaccine the student has received. (This can be another MMR or a single measles shot.)

IMMUNIZATIONS RECOMMENDED FOR INCOMING STUDENTS

- **TETANUS/DIPHTHERIA/ACELLULAR PERTUSSIS (Tdap):** All entering students should have received an immunizing series and booster for tetanus/diphtheria within nine years of entering the College.
- **HEPATITIS B VACCINE:** The Centers for Disease Control and Prevention and the American College Health Association recommend universal vaccination with hepatitis B vaccine. Most infections in this country occur in adolescents and adults. Physical and occupational therapy students are required to complete the hepatitis B series before their affiliations. This series can be completed at the College’s health service at a nominal charge to the student.
- **MENINGOCOCCAL VACCINE:** We support the American College Health Association’s recommendation that students receive a single dose of quadrivalent meningococcal vaccine.
- **VARICELLA VACCINE:** We recommend varicella vaccine for all students who have no prior history of chicken pox (two doses at least one month apart if over 13 years of age).



HEALTH CERTIFICATION FORM

DUE DATES

Fall Admission — July 15

Spring and Summer Admission — One Week before Classes Begin

Ithaca College

Ithaca, New York 14850

Phone 607-274-3177

Fax 607-274-1844

INSTRUCTIONS AND INFORMATION

1. The primary purpose of this form is to assure that immunizations are current and in compliance with New York State law. It also allows us to identify students with special needs and gives a medical history for the provision of health care through the Ithaca College health center.
2. All full-time entering students are required by New York State law to show proof of immunity to measles, mumps, and rubella. Failure to do so will result in the student's not being allowed to attend the College.
3. This form must be completed by all new students and all students who have been away from the College for more than 24 months. Students entering graduate school who were undergraduates at Ithaca College must also complete this form to update their medical record.
4. Information on this form is CONFIDENTIAL; it is for health center use only, will not be released without the student's consent, and will not affect admission status unless the student has not been immunized as required by law.

IDENTIFICATION

College ID Number _____

Name (last, first, middle) _____

Local Address (if available) _____ Zip _____

Home Address (number and street) _____

City _____ State _____ County _____ Zip _____

Home Telephone _____

Cell/Business Telephone _____

Birthdate (Month-Day-Year) _____
M D Y

Sex: Female Male

Ethnicity: White/Non-Hispanic American Indian
 Black or Alaskan Native
 Hispanic Nonresident Alien
 Asian/Pacific Islander Other

Citizenship: U.S. Other _____
(Specify)

Parent Name _____
(last, first)

Occupation _____

Home Telephone _____

Cell/Business Telephone _____

Parent Name _____
(last, first)

Occupation _____

Home Telephone _____

Cell/Business Telephone _____

REGISTRATION DATA

Expected year of graduation: 20____

Undergraduate Student

Graduate Student

School/Academic Unit

Business

Roy H. Park School of Communications

Health Sciences and Human Performance

Humanities and Sciences

Music

Interdisciplinary Studies

International Program Yes No

ENTERING TERM AND YEAR

Fall Spring Summer Year _____

Have you ever been a matriculated student at Ithaca College? **Yes No**

If yes, last year attended _____

Have you ever been a patient at the College health center?

PERSON TO NOTIFY IN CASE OF AN EMERGENCY

Name (last, first) _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Home Telephone _____

Cell/Business Telephone _____

PERMISSION FOR MEDICAL CARE

For students under 18 at time of matriculation:

I hereby give permission to the medical staff of Ithaca College's Hammond Health Center to examine and treat my son or daughter, _____, for all medical problems and injuries occurring while he or she is at school. Furthermore, in the event that time will not allow me to be reached, or that I cannot be reached, I hereby give permission for the College health center physicians to secure necessary consultative care for my child, to include hospitalization, anesthesia, surgery, and other indicated treatment.

Signature: _____ Date _____
(parent or guardian)

PERSONAL MEDICAL HISTORY

PERSONAL MEDICAL HISTORY

Do you now have, or have you ever had, any of the following medical conditions?

Yes No

- Acne (under treatment)
- Alcohol or drug use, problem, or treatment
- Anxiety or nervousness
- Anemia
- Arthritis
- Asthma
- Bipolar disorder/manic depression
- Bleeding trait
- Blood disorders
- Breast disease
- Cancer or malignancy
- Cerebral palsy
- Chicken pox
- Chronic bronchitis/emphysema
- Chronic inflammatory bowel disease (Crohn's, ulcerative colitis)
- Chronic kidney condition
- Depression
- Diabetes mellitus
- Digestive trouble
- Dizziness/fainting
- Eating disorder: bulimia/anorexia nervosa
- Emotional/mental illness
- Fracture/sprains
- Hay fever
- Hepatitis
- Heart disease
- High cholesterol
- HIV/AIDS
- Insomnia/sleep problems
- Kidney stones
- Menstrual problems
- Migraine/recurrent headaches
- Pelvic infection
- Peptic ulcer
- Phlebitis
- Pregnancy
- Rheumatic fever
- Seizure disorder (epilepsy)
- Sexually transmitted disease
- Skin disorder
- Systemic lupus
- Thyroid disorder
- Tobacco use
- Tuberculosis or past positive tuberculin skin test
- Treatment for **active** tuberculosis
- Urinary infection
- Other

If yes to any of the above, explain: _____

Have you had any surgery? If yes, explain: _____

Have you been hospitalized? If yes, reason: _____

ALLERGIES TO DRUGS OR OTHER SEVERE ADVERSE REACTIONS

No known allergies

Reaction (specify)

- Aspirin _____
- Food (specify type) _____
- Insect/bee sting _____
- Latex _____
- Lidocaine/Xylocaine _____
- Penicillin _____
- Sulfa _____
- X-ray contrast _____
- Other (specify) _____

CURRENT MEDICATIONS (frequent or regular)

Please provide name, dosage, and medical indication for all medications you are currently taking:

FAMILY MEDICAL HISTORY

Number of siblings: _____

Check the appropriate box if any of the following diseases apply to your family.

- | Grand-
Parent(s) | parent(s) | Siblings | |
|--------------------------|--------------------------|--------------------------|--------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Alcoholism or chemical dependency |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart disease |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Emotional/mental illness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other (please specify): _____ |
| | | | <input type="checkbox"/> None of the above |

Ithaca College Student Health Service
Hammond Health Center, Rm. 201, 953 Danby Road, Ithaca, NY 14850
Privacy Official: 607-274-3177

Enclosed you will find our “Notice of Privacy Practices,” which describes how medical information may be used and disclosed and how you can get access to this information.

Notice of Privacy Practices Receipt

I acknowledge that I was provided with the “Notice of Privacy Practices” of the medical practice named at the top of this page. Please complete this notice of privacy practices receipt and sign both the receipt and the consent below.

Print Name of Student: _____
Student’s Ithaca College ID: _____
Student’s Date of Birth: _____
Signature of Student: _____
Date: _____

Please check this box if you are under 18:

For Personal Representative of the Student (if a minor):

Print Name of Personal Representative: _____
Describe Personal Representative
Relationship (parent, guardian, etc.): _____
Signature of Personal Representative: _____
Date: _____

Consent for Purposes of Treatment, Payment, or Health Care Operations

I consent to the use or disclosure of my protected health information by the Ithaca College student health services staff for the purpose of diagnosis or treatment, obtaining payment for health care services rendered, or in order to conduct health care operations.

I understand that I have the right to request a restriction or limitation on how and to whom my protected health information is used or disclosed for the above purposes. The Ithaca College Hammond Health Center is not required to agree to such a request, but if agreed upon, the center will comply unless the information is needed to provide me emergency treatment.

The “Notice of Privacy Practices” describes my rights as well as Ithaca College Hammond Health Center’s rights and responsibilities with respect to my protected health information.

Signature of Student (or personal representative if a minor): _____
Name of Student: _____
Date: _____

MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE FORM

New York State Public Health Law requires that all college and university students enrolled for at least six (6) semester hours or the equivalent per semester, or at least four (4) semester hours per quarter, complete and return the following form to Hammond Health Center, Rm. 201, Ithaca College, 953 Danby Road, Ithaca, NY 14850.

Check one box and sign below.

I have or my child (parent complete if child is a minor, under age 18) has

- had the meningococcal meningitis immunization within the past 10 years.
Note: If you (your child) received the meningococcal vaccine available before February 2005 called Menomune, please note this vaccine's protection lasts for approximately three to five years. Revaccination with the new conjugate vaccine called Menactra should be considered within three to five years after receiving Menomune.

- read, or 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 at this time.

Student's Signature: _____ Date: _____
(parent/guardian if student is a minor)

Print Student's Name: _____ Student's Date of Birth: _____

Student's E-Mail Address: _____ Student's ID#: _____

Student's Mailing Address: _____

Student's Phone Number: _____

If you have not yet had the meningococcal vaccine and are interested in receiving it, you may contact the Hammond Health Center for an appointment. As stated on the cover page, we can provide all the required and recommended immunizations, as well as the PPD test; however, we encourage you to have these prior to coming to Ithaca.

**TO BE COMPLETED BY HEALTH CARE PROFESSIONAL
(PLEASE COMPLETE BOTH FRONT AND BACK)**

Patient Name: _____ Birthdate: _____

Has the patient received BCG vaccine? No Yes If yes, date(s): _____

TUBERCULOSIS ASSESSMENT

A tuberculin skin test is **required** for any entering students **with risk factors** for tuberculosis exposure or disease as defined by the U.S. Centers for Disease Control and Prevention.

(1) **Was the patient born in or did s/he reside in a country where TB is endemic?** No Yes

This includes all countries **EXCEPT** the following: *United States, Virgin Islands (USA), American Samoa, Australia, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Jamaica, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, New Zealand, Norway, Saint Kitts and Nevis, Saint Lucia, San Marino, Sweden, Switzerland, United Kingdom*

(2) **Has s/he worked in health care facilities, prisons, or homeless shelters?** No Yes

(3) **Has s/he ever had close contact with a person with infectious TB?** No Yes

(4) **Does s/he have any underlying immunocompromising medical conditions** No Yes

such as diabetes mellitus, chronic renal failure, hematologic disorders and malignancies, HIV infection, or are they on a chronic immunosuppressive therapy?

(Medical providers may refer to the CDC website at www.cdc.gov/nchstp/tb/pubs/corecurr for further information.)

Certifying health professional signature: _____
(required)

If the answer to any of the above tuberculosis assessment questions is YES, then a PPD skin test must be done within the six months prior to expected arrival on campus and it must be read 48–72 hours after placement. A chest x-ray is required if the skin test is positive.

Students who have had a positive PPD in the past are not required to have the PPD repeated but must submit the report of a chest x-ray that was done subsequent to the positive PPD test. *Prior vaccination with BCG is not a contraindication to PPD testing.*

For all students undergoing PPD testing or with prior positive PPD test, please complete the following:

Date PPD administered: _____ Date interpreted (within 48–72 hours): _____

Induration: _____ (in mm)

Certifying health professional signature: _____
(required)

If PPD is positive, please note the following:

- Chest x-ray is required subsequent to positive PPD result. Attach copy of report. Do not send film.
- Has student had INH? YES, dates: _____ NO _____
- Does student need additional follow-up care regarding their positive PPD at the Ithaca College Health Center? YES, NO

TO BE COMPLETED BY HEALTH CARE PROFESSIONAL

IMMUNIZATION RECORD DATES MUST BE WRITTEN MO/DAY/YR	Date vaccine given (MO/DAY/YR) Please read attached letter for detailed instructions.	Initials of certifying health professional	Physician-diagnosed disease history (date of onset)	Serology date/results (copy of lab report MUST be attached)						
MMR (REQUIRED)	#1 <table style="display: inline-table; border: none;"><tr><td style="text-align: center;">month</td><td style="text-align: center;">day</td><td style="text-align: center;">year</td></tr><tr><td><input type="text"/><input type="text"/></td><td><input type="text"/><input type="text"/></td><td><input type="text"/><input type="text"/></td></tr></table>	month	day	year	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>			
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THE FOLLOWING ARE RECOMMENDED BUT NOT REQUIRED FOR ADMISSION. Provide date of most recent tetanus vaccine.										
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CURRENT MEASUREMENTS

Height ___ feet ___ inches Weight _____ lbs Blood pressure ____/____ Hgb _____ or HCT _____

ONGOING MEDICAL CARE

Is the student under care for a chronic condition or serious illness? Yes No

Diagnosis: _____

Please attach or forward any medical records that may be needed in order to provide appropriate care to this student while they are at college. Also, since we cannot automatically assume responsibility for a student's care without their willing participation, please instruct them to contact the Ithaca College health center for an appointment.

★ If you have further information to provide, please include clinical reports if appropriate with this form or send to the attention of David E. Newman, M.D., Hammond Health Center, Rm. 201, Ithaca College, 953 Danby Road, Ithaca, NY 14850.

Certifying signature _____ Name of physician or health care facility _____

Street _____ Telephone _____

City _____ State _____ Zip _____ Date _____

INTRAMURAL SPORTS PARTICIPATION (if student plans on participating in intramural or club sports): In my medical judgment, this student has no medical problems that would prohibit participation in intramural or club sports at Ithaca College.

Signature: _____, MD/DO/PA/NP Date _____

If student is not cleared for participation, please explain: _____

Signature: _____, MD/DO/PA/NP Date _____

When all sections are completed, please mail this form to the following address:

Ithaca College, Hammond Health Center, Health Certification Form, 953 Danby Road, Ithaca, NY 14850.

If you have questions, please contact, Donna Mistler, the health form coordinator, at dmistler@ithaca.edu, 607-274-3286 (phone), or 607-274-1844 (fax).

For office use only

Entered by: _____ Date: _____ Comments: _____

Reviewed by: _____ Date: _____ Comments: _____