

Spring, 2008

Dear Incoming Transfer Student,

We at Marist Health Services are eager to help make your health care transition as smooth as possible.

Marist Health Services, located in Room 350 of the Student Center, provides care to all full-time undergraduate students. The office is staffed by physicians, nurse practitioners, physician assistants, nurses and clerical staff. After hours or in emergencies, students are referred to the Emergency Department of Saint Francis Hospital, which is across the street from the Marist College campus.

Enclosed you will find six Health Services forms which must be completed and signed. If you do not have a record of a recent physical exam (within two years), you should schedule a visit with your primary care provider as soon as possible so that all forms can be received at Marist College by the deadline of **July 15, 2008**.

Office of Health Services  
Marist College  
Poughkeepsie, NY  
12601-1387  
telephone: 845-575-3270  
fax: 845-575-3275  
e-mail:  
Health.Services@Marist.edu

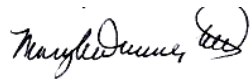
**You may send a copy of your immunization record and physical exam from your previous college (most schools will fax this to us on your request).**

We suggest that you keep a copy of all your health forms for your own reference.

**Please note that students will not be allowed to register for classes or remain on campus unless proof of immunizations is documented.** (NYS Public Health Law #2165)

We look forward to working with you to ensure a healthy Marist experience.

Sincerely,



Mary L. Dunne, MD  
Medical Director

Enc:     MMR Vaccination Information  
          Mandatory Immunization Information  
          Physical examination form – to be completed by Health Practitioner  
          Medical history / Emergency contact / Health Insurance information  
          Medical Authorization and Consent form  
          Mandatory Meningitis Information

## New York State Requirement

### Measles, Mumps and Rubella (MMR) Vaccination Information

New York State Public Health Law 2165 requires undergraduate, graduate, and professional students to demonstrate acceptable proof of immunity against measles, mumps and rubella to the schools in which they are enrolling. The law applies only to students born on or after January 1, 1957.

**Entering students are required to submit proof of immunization or documentation of medical or religious exemption. Your immunization information must be filed with the Marist College Health Services office by fax at 845-575-3275 or by mail at Marist College Health Services no later than 2 weeks after your enrollment.**

Marist College is mandated by New York State law to enforce this requirement. As part of the compliance procedure, Marist College submits an annual report to the New York State Department of Health attesting to the status of our students' immunizations. Marist College is also subject to audits by the State.

**Note: Fines resulting from any such audit conducted by the State that arise from an individual student's failure to comply with this law will be passed on to that student.**

#### Required Vaccines

One of the following is required:

- Two measles vaccines, one mumps vaccine and one Rubella vaccine
- Two measles, mumps, rubella vaccines (MMR1 and MMR2)
- A blood test showing immunity to measles, mumps and rubella.

#### Acceptable Proof of MMR Immunization

You may submit **any one of the following** as proof of MMR immunization:

- The Marist College MMR Immunization Form (included) completed and signed by your doctor

OR

- A copy of your health care provider-certified immunization record

OR

- An immunization record from your undergraduate or high school or the armed services. (Proof of honorable discharge from the armed services within 10 years of enrollment in Marist College will allow you to attend classes pending actual receipt of your immunization records.)

#### Exceptions

Proof of MMR immunization is not necessary if any of the following exceptions apply:

- If you are a student born before January 1, 1957
- If you are unable to receive a vaccine for medical reasons and your doctor writes a note to this effect and signs it
- If you are unable to receive a vaccine for religious reasons and you submit documentation. In the event of an outbreak of measles, mumps or rubella, you will not be allowed to attend class.

**If immunization is needed:** Dutchess County Health Department 387 Main Street, Poughkeepsie, NY 12601 845-486-3401

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**I have read, or have had explained to me, the information regarding NYS MMR requirements.**

**Student name** (Please Print) \_\_\_\_\_

**Student Signature** \_\_\_\_\_

(Parent must sign if student is younger than 18 years of age.)



# MARIST

## Physical Exam (To be filled out by Health Practitioner)

Name: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_

Date of this Examination: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Eye examination:** Glasses Yes \_\_\_ No \_\_\_ Contact Lenses Yes \_\_\_ No \_\_\_  
Best vision Right 20/\_\_\_\_ Left 20/\_\_\_\_

	<u>Normal</u>	<u>Abnormal</u>	<u>Notes of Abnormality</u>
Skin	_____	_____	_____
Hearing	_____	_____	_____
Ear, Nose & Throat	_____	_____	_____
Neck	_____	_____	_____
Cardiovascular	_____	_____	_____
Lungs	_____	_____	_____
Breasts	_____	_____	_____
Abdomen	_____	_____	_____
Back/Extremities	_____	_____	_____
Reflexes	_____	_____	_____
Urinalysis/ urine dip	_____	_____	_____

Hb \_\_\_\_\_ or Hct \_\_\_\_\_ PPD results \_\_\_\_\_ Date read \_\_\_\_\_

1. Is this student presently under medical treatment? Yes \_\_\_ No \_\_\_  
If yes, explain: \_\_\_\_\_  
\_\_\_\_\_
2. Is this student capable of normal physical exercise or athletic activity? Yes \_\_\_ No \_\_\_  
If no, explain: \_\_\_\_\_  
\_\_\_\_\_
3. Is this student receiving or has he/she ever received professional help for an emotional or psychological problem? Yes \_\_\_ No \_\_\_  
If so, when? \_\_\_\_\_ Name of Therapist/Psychiatrist: \_\_\_\_\_  
Phone \_\_\_\_\_

**Please Note Any Allergies or Sensitivities:** \_\_\_\_\_

Impression and Recommendations: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Physician Printed Name

\_\_\_\_\_  
Physician Address

\_\_\_\_\_  
Physician Telephone Number

\_\_\_\_\_  
Physician Fax Number

# MARIST

## Medical History

Please answer all questions to aid Marist Health Professionals with providing appropriate medical treatment.

1. Do you have or ever have any of the following? If so, please include date.

ADHD	Yes___ No ___	Heart disease	Yes___ No ___
Allergies	Yes___ No ___	Hypertension	Yes___ No ___
Asthma	Yes___ No ___	Kidney Disease	Yes___ No ___
Cancer	Yes___ No ___	Mononucleosis	Yes___ No ___
Diabetes	Yes___ No ___	Seizure Disorder	Yes___ No ___
Eating disorder	Yes___ No ___	Other (specify)	Yes___ No ___

If yes, explain: \_\_\_\_\_

2. Have you ever received professional help for an emotional or psychological problem? Yes\_\_\_ No\_\_\_

If yes, explain: \_\_\_\_\_

Name of Therapist/Psychiatrist \_\_\_\_\_

Phone \_\_\_\_\_

3. Do you have any physical impairment such as paralysis, loss of vision, hearing? Yes\_\_\_ No\_\_\_

If yes, explain \_\_\_\_\_

4. Are you currently taking any medication? Yes\_\_\_ No\_\_\_ If yes, explain \_\_\_\_\_

5. Are you allergic to any medication? Yes\_\_\_ No\_\_\_ If yes, explain \_\_\_\_\_

**FAMILY HISTORY:** is there a history within your primary family (parents and siblings) of

Cancer Yes\_\_\_ No\_\_\_ Diabetes Yes\_\_\_ No\_\_\_

Heart Disease Yes\_\_\_ No\_\_\_ Asthma Yes\_\_\_ No\_\_\_

Other \_\_\_\_\_

If yes, explain \_\_\_\_\_

**Emergency Contact Information:** Please list both parents, if available, and an additional adult in case a parent can't be reached. (Please Print)

\_\_\_\_\_  
Name

\_\_\_\_\_  
Name

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Relationship

(\_\_\_\_\_) \_\_\_\_\_  
Home #

(\_\_\_\_\_) \_\_\_\_\_  
Home #

(\_\_\_\_\_) \_\_\_\_\_  
Home #

(\_\_\_\_\_) \_\_\_\_\_  
Work #

(\_\_\_\_\_) \_\_\_\_\_  
Work #

(\_\_\_\_\_) \_\_\_\_\_  
Work #

(\_\_\_\_\_) \_\_\_\_\_  
Cell #

(\_\_\_\_\_) \_\_\_\_\_  
Cell #

(\_\_\_\_\_) \_\_\_\_\_  
Cell #

**Health Insurance – Please attach copy of the front and back of your insurance card**

Insurance name

Policy holder's name

Policy number

# MARIST

## Medical Authorization And Consent Form Must be completed by all students

### FOR STUDENT

I hereby consent to treatment by Marist College Health Services staff.

I agree to allow Saint Francis Hospital to provide Marist College Health Service with information concerning any medical treatments I may require during the Marist College academic year. I understand that this information is necessary for appropriate follow up care by Marist Health Service or private physicians to whom I may be referred.

\_\_\_\_\_  
Student signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

### FOR PARENTS

**STUDENTS UNDER 18 YEARS OLD CANNOT RECEIVE ANY MEDICAL TREATMENT WITHOUT PARENTAL CONSENT.**

I hereby consent to have Marist College Health Service, Saint Francis Hospital, or a medical professional designated by either, to treat \_\_\_\_\_ (Student's name - Please Print) in the event that I cannot be contacted, or in the judgment of medical professionals, immediate attention is required prior to my being contacted.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Print Parent/Guardian Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to student

### PARENTS, PLEASE NOTE:

Parental notification of treatment for illness or injuries of any student over 18 years of age is the responsibility of the student. Marist College staff will actively encourage students to notify their parents/guardians to inform them of illness or medical treatment.

# MARIST

## MANDATORY MENINGITIS INFORMATION

As the Health Service Director at Marist College, I write to inform you about meningococcal disease, a potentially fatal bacterial infection, commonly referred to as meningitis. On July 22, 2003, Governor Pataki signed New York State Public Health Law §2167, requiring colleges and universities to distribute information about meningococcal disease and vaccinations to all students.

Meningitis is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. If not treated early, meningitis can lead to swelling of the fluid surrounding the brain and spinal column, as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even death.

Cases of meningitis among teens and young adults 15 to 24 years of age have doubled since 1991. The disease strikes about 3000 Americans each year and claims about 300 lives. Between 100 and 125 meningitis cases occur on college campuses and as many as 15 students will die from the disease.

A vaccine is available that protects against four types of the bacteria that cause meningitis in the United States (types A, C, Y and W-135); these types cause nearly two-thirds of the meningitis cases among college students.

It is mandatory that you review the enclosed information, complete the form below and return it to Marist Health Service.

## MANDATORY MENINGITIS VACCINATION RESPONSE FORM

New York State Public Health Law §2167 mandates 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 the following form.

I have/my child has: (check one box and sign below)

had the meningococcal meningitis immunization within the past 10 years

Menomune: date received \_\_\_\_\_

or

Menactra: date received \_\_\_\_\_

read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine.

**Student name** (Please Print) \_\_\_\_\_

**Student Signature** \_\_\_\_\_

(Parent must sign if student is younger than 18 years of age.)

Date \_\_\_\_\_ CWID# \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_