Dear Summer Pre-College Student and Family,

Welcome to Marist College!

Please review the attached Health Forms. Students will be informed of health and emergency information during orientation on arrival day. If students have health questions or needs on campus, they should contact their Resident Assistant for direction and support. In emergencies, students are referred to the local emergency facilities. Parents will be contacted as soon as possible in the unlikely event of any emergency or serious health issue.

Following this letter are health forms for parents or legal guardians to complete and sign. Please note that:

- there is a form for the student’s health care provider to complete about participation in activities
  - a similar form completed within one year can be submitted for review
  - it must specify whether the student has any physical restrictions
  - it must include the student’s immunization record; NYS immunization compliance is strongly recommended, please see below.

- a copy of these forms will be in the custody of the faculty chaperone for any off-campus event or field trip
- we recommend that you retain a copy of these health forms for your records
- students will not be allowed to move into Marist housing until all health forms have been received

Forms can be scanned and emailed to precollege@marist.edu (please put “Summer Pre-College forms” in the subject line), or sent via regular mail to:

Office of Admission
Marist College
3399 North Road
Poughkeepsie, NY 12601-1387

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

To be compliant with New York Public Health Law 2165, the MMR requirement, you will need to submit your health records indicating that you have in fact had at least:

- 2 MMR vaccines
- or
- 2 Measles vaccines and 1 Mumps vaccine and 1 Rubella vaccine
- or
- 1 MMR titer showing that you are immune

New York Public Health Law 2167:
New York State Public Health Law 2167 requires that colleges and universities distribute the following 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. The disease strikes about 2500 Americans each year and claims about 300 lives. Cases of meningitis among teens and young adults 15 to 24 years of age have increased by almost 60% since the 1990’s. Freshmen living in dormitories are up to six times more likely to get the disease than other people. Meningitis is spread through air droplets and direct contact with someone who is infected. Students can reduce their risk by getting vaccinated and by not sharing things like utensils, beverages, cigarettes, etc. 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. Protection lasts approximately 3 to 5 years. The CDC advises that students who received the vaccine at age 11 – 12 should receive a booster before college. For more information, see http://www.cdc.gov/ meningitis/index.htm
Summer Pre-College Health Form

Last Name: ____________________________  First Name: ____________________________  Middle Initial: ____________________________

Birthdate: ____________________________  CWID#: ____________________________  Date: ____________________________

Mailing Address: ____________________________________________________________

City: ____________________________  State: ____________________________  Zip: ____________________________  Country: ____________________________

Academic Program: ____________________________

MEDICAL HISTORY (PARENTS TO COMPLETE)

1. Does your student have or has your student had any of the following? If so, please include pertinent details and date(s). If yes, explain: ____________________________________________________________

   ADHD □ Yes □ No  Heart Disease □ Yes □ No
   Allergies □ Yes □ No  Hypertension □ Yes □ No
   Asthma □ Yes □ No  Mononucleosis □ Yes □ No
   Cancer □ Yes □ No  Seizure Disorder □ Yes □ No
   Diabetes □ Yes □ No  Surgery □ Yes □ No
   Eating Disorder □ Yes □ No  Other □ Yes □ No

2. Has your student ever received professional help for an emotional or psychological problem? □ Yes □ No

   If yes, explain: ____________________________________________________________

3. Name of Therapist/Psychiatrist: ____________________________  Phone: ____________________________

4. Does your student have any physical impairment such as paralysis, vision loss, hearing loss? □ Yes □ No

   If yes, explain: ____________________________________________________________

5. Is your student currently taking any medication? □ Yes (If yes, please complete page 6) □ No

6. Does your student have any food, environmental, or medication allergies? □ Yes □ No

   If yes, explain: ____________________________________________________________

7. Is there anything additional you would like us to know about your student? Use additional page if needed.

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: ____________________________
Last Name: ___________________________ First Name: ___________________________ Middle Initial: ___________________________

Birthdate: ___________________________ CWID#: ___________________________ Date: ___________________________

**PHYSICAL EXAMINATION**

- **Height:** ____________  
- **Weight:** ____________  
- **Blood Pressure:** ____________  
- **Pulse:** ____________

**EYE EXAMINATION**

- **Best Vision:** ____________  
  - Right 20/____  
  - Left 20/____  
  - □ Glasses  
  - □ Contacts

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<thead>
<tr>
<th>Normal</th>
<th>Abnormal</th>
<th>Notes of Abnormality</th>
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<td>Skin</td>
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<td>Hearing</td>
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<td>Ear, Nose &amp; Throat</td>
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<td>Cardiovascular</td>
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<td>Back/Extremities</td>
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<td>Reflexes</td>
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<td>Urinalysis/Urine Dip</td>
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<tr>
<td>Hb or Hct if indicated</td>
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| PPD if indicated | | mm

**PLEASE INCLUDE A COPY OF THE STUDENT’S CERTIFIED IMMUNIZATION RECORD**

1. Is this student presently under treatment for a medical condition?  
   - □ 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:  
- □ Normal exam, this student has no activity restrictions  
- □ Other (please include an additional page if needed) _________________________________________________________

Signature: ___________________________________________ Printed Name: ___________________________

Address: __________________________________________________________________________________

Telephone Number: ___________________________ Fax Number: ___________________________
Last Name: ___________________________ First Name: ______________________ Middle Initial: ________________

CWID#: ______________________________ Date of Birth: ________________________________

PLEASE COPY THE FRONT AND BACK OF YOUR HEALTH INSURANCE CARD ON THIS PAGE (or include separate page). This is not required for care on the Marist campus, but in case of need for off-campus care or prescriptions.
Last Name: ___________________________ First Name: ___________________ Middle Initial: ________________

CWID#: ______________________________ Date of Birth: ________________________________

Medical Authorization and Consent

Students under 18 years old cannot receive treatment without parental consent.

I hereby consent for a medical professional designated by the College to treat

__________________________________________
(Student’s name - Please Print)

in the event that I cannot be contacted or, if in the judgment of medical professionals, immediate attention is required prior to my being contacted.

I agree to allow treating medical professionals to provide Marist College with information concerning any medical treatments the above student may require while at Marist College. I understand that this information is necessary for appropriate follow-up care by Marist or the private physicians to whom the above may be referred.

Parent/Legal Guardian Signature                Print Parent/Legal Guardian Name           Date

For students who will be 18 years of age or older during the program:

I hereby consent to treatment by Marist College staff. In the event of an emergency, I consent to treatment by emergency department/medical staff.

I agree to allow treating medical professionals to provide Marist College with information concerning any medical treatments I may require during the Marist Summer Pre-College Programs. I understand that this information is necessary for appropriate follow-up care by Marist or the private physicians to whom I may be referred.

Student Signature: ___________________________ Date: ___________________________
Name: ____________________________________________________________

LAST                          FIRST                                    MIDDLE

CWID#: ___________________________  Date of Birth: ___________________________

MEDICATION FORM

Please list all medications taken, whether on a regular or as-needed basis

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<tr>
<th>MEDICATION</th>
<th>DOSE (mg)</th>
<th>HOW OFTEN TAKEN</th>
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I attest that my student understands how to take the above medication(s) and how to securely and appropriately store these medication(s) in a dormitory environment. I give my permission for my student to self-administer the above medication(s).

Parent/Guardian Signature: ______________________________________________________

Print Parent/Guardian Name: __________________________________ Date: ________________