Congratulations on your acceptance to Marist College!

As part of your enrollment requirements, you must:

- Submit proof of Measles, Mumps, and Rubella (MMR) immunizations. See Vaccination Requirements Form for compliance requirements.
- Complete and sign the Meningitis Vaccination Response Form.
- Complete the Medical History/Emergency Contact Form.
- Complete the TB Screening Questionnaire.
- Have your Health Care Provider complete the Physical Examination Form.
- Complete the Insurance Form.
- Complete the Medical Authorization and Consent Form.

Please note these important guidelines:

- Your physical exam must be within 12 months of your entry date.
- You will not be allowed to register for classes or move into campus housing unless this information has been received.
- ALL varsity athletes (excluding club or intramural) must complete this information. This is in addition to any physicals and/or documentation that the Department of Athletics may also request.
- If you will be under 18 when starting school, a parent or guardian must sign all forms.
- If you are a transfer student, you may request these forms from your previous college.

Submit all information by **June 30 for the fall semester and January 15 for the spring semester.**

Mail:
Marist College
Office of Enrollment Services
Lowell Thomas 120
3399 North Road
Poughkeepsie, NY 12601

Fax:
(845) 575-3215

Email:
Email ALL completed documents as a PDF to immunization@marist.edu. Do NOT send directly to Health Services.
New York State Public Health Law 2165 requires that undergraduate, graduate, and professional students taking 6 or more credit hours demonstrate acceptable proof of immunity against measles, mumps and rubella to the schools in which they are enrolling.

Students who are not in full compliance with the requirements of the New York State Public Health Law 2165 will NOT be allowed to remain enrolled in courses after 30 days from the start of the term and may forfeit all or part of their tuition.

REQUIRED VACCINES:
- Measles – 2 doses of live vaccine: the first given no more than 4 days before your first birthday, and the second at least 28 days after the first
- Mumps – 1 dose
- Rubella – 1 dose

ACCEPTABLE PROOF OF IMMUNITY:
- Certified Vaccination Administration Record from your doctor
- Immunization records from your undergraduate institution, 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)
- Physician documented proof of disease (not acceptable for rubella)
- Blood tests proving immunity to Measles, Mumps and Rubella (a.k.a. Blood Antibody Titer)

Please note that New York State immunization requirements may differ from those of other states and you may need to receive additional vaccinations in order to be in compliance.

YOUR IMMUNIZATION RECORDS SHOULD:
- Clearly indicate the vaccines, dates, name and location of the doctor or clinic
- Be stamped and signed by the doctor or clinic
- Be easily readable
- Include your name (current name as enrolled, if different from childhood name), birthdate, and CWID. You can add this to your immunization record or include it in an email or on a separate sheet of paper

EXCEPTIONS:
- If you are a student born before January 1, 1957
- If you are unable to receive a vaccine for medical reasons your doctor writes a note to this effect and signs it
- If you are unable to receive a vaccine for religious reasons, you must submit documentation. In the event of an outbreak of measles, mumps or rubella, you may not be allowed to attend classes or remain on campus
- Entering students are required to submit proof of immunity (usually 2 MMR vaccinations) or documentation of medical or religious exemption. Medical exemptions must be certified by a licensed physician, physician assistant or nurse practitioner. Religious exemption documentation should be notarized.
- If the program you are enrolling in is 100% online

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Fax:
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Email:
immunization@marist.edu. Do NOT send directly to Health Services.
New York State Public Health Law 2167 requires that colleges and universities distribute information about meningococcal disease and vaccinations to all students.

It is mandatory that you review this information, sign, and return this form to Marist College.

Check one box and sign below

I have:

☐ had the meningococcal immunization within the past 5 years. The vaccine record is attached.

Note: The Advisory Committee on Immunization Practices recommends that all first-year college students up to age 21 years should have at least 1 dose of Meningococcal ACWY vaccine not more than 5 years before enrollment, preferably on or after their 16th birthday, and that young adults aged 16 through 23 years may choose to receive the Meningococcal B vaccine series. College and university students should discuss the Meningococcal B vaccine with a healthcare provider.

Menomune: date rec’d _______, OR Menactra: date rec’d _______, OR Other Meningitis Immunizations: date rec’d _______ date rec’d _______

☐ read, or have had explained to me, the information regarding meningococcal disease. I understand the risks of not receiving the vaccine. I have decided that I (my child) will NOT obtain immunization against meningococcal disease.

Student Name: _______________________________ Student Signature: _______________________________

Meningococcal disease is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. If not treated early, meningococcal disease 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. Meningococcal disease 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. This booster dose at age 16 enhances protection during the years when the student is at the greatest risk of meningococcal disease.

Teens and young adults can also be vaccinated against the “B” strain. Students should discuss this vaccine with their health care provider. For more information, see http://www.cdc.gov/meningitis/index.html.

Return by:

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3399 North Road
Poughkeepsie, NY 12601

Fax: (845) 575-3215

Email: Email ALL completed documents as a PDF to immunization@marist.edu. Do NOT send directly to Health Services.
Last Name: ___________________________ First Name: ___________________________ DOB: __________ Date: __________

Gender: ___________________________ CWID: ___________________________ Cell Phone #: ___________________________

Home Address: ____________________________________________

Email: ____________________________________________

PAST MEDICAL HISTORY: HAVE YOU HAD ANY OF THE FOLLOWING?

- ADD/ADHD
- Anxiety
- Asthma
- Bipolar Disorder
- Bleeding Disorder
- Cancer
- Concussions
- Depression
- Diabetes
- Digestive Problems
- Eating Disorder
- Heart Disease
- High Blood Pressure
- Kidney Disease
- Mono/EBV
- Psychosis
- Seasonal Allergies
- Seizure Disorder
- Skin Disease
- Syncope
- Thyroid Disease

Food Allergies: ____________________________________________

Medication Allergies: ____________________________________________ Anaphylaxis: ____________________________________________

Past Surgical Hx: ____________________________________________

Do you have any physical impairment such as decreased mobility, paralysis, vision loss, hearing loss?

Emotional/Psychological needs: ____________________________________________

Name of Psychiatrist/Therapist, number: ____________________________________________

Name of Primary care Practitioner, number: ____________________________________________

Daily Medications/dosages: ____________________________________________

EMERGENCY CONTACTS

Please list both parents if available and an additional adult in case parents cannot be reached

Name: ___________________________ Name: ___________________________ Name: ___________________________

Relationship: ___________________________ Relationship: ___________________________ Relationship: ___________________________

Cell #: ___________________________ Cell #: ___________________________ Cell #: ___________________________

Home #: ___________________________ Home #: ___________________________ Home #: ___________________________

Work #: ___________________________ Work #: ___________________________ Work #: ___________________________
Last Name: __________________________ First Name: __________________________ DOB: _____________ Date: ______________

Gender: __________________________ CWID: __________________________ Cell Phone #: __________________________

Home Address: __________________________

Email: __________________________

Please answer the following questions:

1. Have you ever had a positive TB skin test?  [ ] Yes  [ ] No

2. Have you ever had close contact with anyone who was sick with TB?  [ ] Yes  [ ] No

3. Have you been an employee or volunteer in a high-risk setting (e.g. correctional facility, nursing home, homeless shelter, hospital, other health care facility)?  [ ] Yes  [ ] No

4. 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

5. Have you ever traveled* to/in one or more of the countries listed below? (If yes, please CHECK the country/ies)  [ ] Yes  [ ] No

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

If the answer is YES to any of the above questions, Marist College requires that a health care provider complete a Tuberculosis Risk Assessment (available at www.marist.edu/healthservices/healthforms)

If the answer to all of the above questions is NO, no further testing or further action is required. Be advised, however, that a TST is required for many community service activities at Marist College.

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2014. Countries with incidence rates of greater or equal to 20 cases per 100,000 population. For future updates, refer to http://apps.who.int/ghodata/?vid=510
Persons with any of the following are candidates for either Mantoux tuberculin skin test (TST) with purified protein derivative (PPD) tuberculin or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented. If a previous positive test has been documented, please attach details of evaluation and treatment.

Health care provider to complete

**RISK FACTORS**

Recent close contact with someone with infectious TB disease
☐ Yes  ☐ No

Foreign-born from (or travel* to/in) a high-prevalence area (e.g. Africa, Asia, Eastern Europe, Central or South America, and Russia)
*The significance of the travel exposure should be discussed with a health care provider and evaluated.

☐ Yes  ☐ No

Fibrotic changes on a prior chest x-ray suggesting inactive or past TB disease
☐ Yes  ☐ No

HIV/AIDS
☐ Yes  ☐ No

Organ transplant recipient
☐ Yes  ☐ No

Immunosuppressed (equivalent of >15 mg /day of prednisone for >1 month or TNF-Tumor Necrosis Factor–alpha antagonist, or immunosuppressive drug therapy following organ transplantation)
☐ Yes  ☐ No

History of illicit drug use
☐ Yes  ☐ No

Resident, employee, or volunteer in a high-risk congregate setting (e.g. correctional facilities, nursing homes, homeless shelters, hospitals, other health care facilities)
☐ Yes  ☐ No

Medical condition associated with increased risk of progressing to TB disease if infected: 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 or gastrectomy; chronic malabsorption syndrome; low body weight (i.e. 10% or more below ideal for the given population)
☐ Yes  ☐ No

**1. SIGNS OR SYMPTOMS**

Does the student have signs or symptoms of active tuberculosis disease?
☐ Yes  ☐ No

If No, proceed to 2 or 3.

If Yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated
2. HOW TO TEST
At the present time, the Mantoux test is the only acceptable TST. To perform this test, inject 0.1ml of purified protein derivative (PPD) tuberculin containing 5 tuberculin units (TU) intradermally into the volar (inner) surface of either forearm.

A history of BCG vaccination should not preclude tuberculin skin testing of students. TST can be administered during pregnancy.

If a student has recently received a live virus vaccination, skin testing should be delayed for 4-6 weeks after the student received the vaccination. However, a TST can be performed on the same day as live virus administration without compromising the integrity of the result.

Two-step testing is particularly important and should be considered for the initial skin testing of persons who will be retested periodically, e.g. health profession students, workers, and volunteers. Two-step testing is more reliable in identifying remote infection (e.g. infection in childhood). If the first test is positive, the person should be considered infected. If the first test is negative, a repeat test should be administered 1-3 weeks later. If the second test is positive, consider the person infected. If there is documentation of a negative TST within the prior 12 months, only one TST needs to be done, and this is considered the second of the two-step tests.

3. HOW TO INTERPRET THE 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:_____/_____/_____ Lot #:________________________ Administered by ____________________________

Date read:_____/_____/_____

Read by:_____________________________

RESULT:____ mm induration

INTERPRETATION: □ positive  □ negative

Date given:_____/_____/_____ Lot #:________________________ Administered by ____________________________

Date read:_____/_____/_____

Read by:_____________________________

RESULT:____ mm induration

INTERPRETATION: □ positive  □ negative

>5mm is positive in the following:
• 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
• Immunosuppressed persons: taking equivalent of >15 mg prednisone for > 1 month; taking a TNF-alpha antagonist
• HIV-infected persons

>10 mm is positive in the following:
• Persons born in a high prevalence country or who resided in one for a significant* amount of time
• History of illicit drug use
• Mycobacteriology laboratory personnel
• History of resident, worker, or volunteer in high-risk congregate settings
• Persons with the following clinical conditions: silicosis; diabetes mellitus; chronic renal failure; leukemias and lymphomas; head, neck or lung cancer; low body weight (>10% below ideal); gastrectomy or intestinal bypass; chronic malabsorption syndromes.

>15 mm is positive in the following
• Persons with no known risk factors for TB disease
Last Name: __________________________ First Name: __________________________ DOB: __________ Date: __________
Gender: __________________________ CWID: __________________________ Cell Phone #: __________________________

4. INTERFERON GAMMA RELEASE ASSAY (IGRA)
Date obtained: ____/____/____ (specify method)  □ QFT-G  □ QFT-GiT  □ T-Spot  □ other____
Result:  □ negative  □ positive  □ indeterminate  □ borderline  □ (T-spot only)

5. CHEST X-RAY: (REQUIRED IF TST OR IGRA IS POSITIVE)
Date of chest x-ray: ____/____/____ Result:  □ normal  □ abnormal  □ (attach full interpretation)

What to do when the TST or IGRA is positive
Persons with a positive TST or IGRA must undergo chest radiography and medical exam. If any x-ray changes or signs and symptoms of active TB are identified, active TB disease must be excluded.

If the chest x-ray and medical exam are normal, treatment for latent tuberculosis infection (LTBI) is recommended since this greatly reduces the risk of TB infection progressing to TB disease in the student and serves to reduce the burden of TB in the United States. Treatment is most important for those with a particularly high risk for progression from latent infection to active disease including individuals who had a TST conversion within 2 years and those with HIV/AIDS or other clinical conditions associated with a suppressed immunity.

Treatment with INH daily for nine months is the preferred regimen; however other regimens may be appropriate. (www.cdc.gov/tb/pubs/LTBI/treatment.htm: Guide for Primary Health Care Providers: Targeted Tuberculin Testing and Treatment of LTBI.)

Completion of treatment is a high priority. Students can be followed regularly while at Marist College and monitored for compliance with and possible side effects of or adverse reactions to treatment.

Post-treatment follow up should include providing the student documentation of TST or IGRA results, chest radiograph results, and the dosage and duration of medication treatment. Students who have completed LTBI therapy should be educated regarding signs and symptoms of TB disease and instructed to seek medical care immediately upon developing any signs or symptoms of TB.

6. DETAILS OF RECOMMENDATION AND TREATMENT:

______________________________________________
______________________________________________
______________________________________________
______________________________________________

Health care provider name printed: __________________________
Health care provider signature: __________________________ Date: __________
Address: __________________________ City: __________________________ State: ______ Zip code: __________
Phone: __________________________ Fax: __________________________
Last Name: __________________________ First Name: __________________________ DOB: __________ Date: __________
Gender: __________________________ CWID: __________________________ Cell Phone #: __________

**Please include a copy of immunization records. | Healthcare provider to complete.**

Height: __________ Weight: __________ Blood Pressure: __________ Pulse: __________
Eye examination (best vision): Right: 20/________ Left: 20/_________ glasses: _________ contacts: _________

<table>
<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>Reflexes</td>
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<tr>
<td>Urinalysis/ urine dip</td>
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Hb__________ or Hct__________

TST/PPD (required for many community service activities) mm __________ Date read __________

Please include a copy of the student’s Certified Vaccine Administration Record for submission

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 _________ No restrictions
   _________ Other: ________________________________________________

Signature: __________________________ Printed Name: __________________________
Address: __________________________ Telephone Number: __________________________
Fax Number: __________________________
Last Name: ___________________________ First Name: ___________________________ DOB: __________ Date: __________

Gender: ___________________________ CWID: ___________________________ Cell Phone #: ___________________________

If you have coverage other than the Marist College student accident and sickness plan, please copy the front of your health insurance card here (or insert another page with a copy of the front of that card).

If you have coverage other than the Marist College student accident and sickness plan, please copy the back of your health insurance card here (or insert another page with a copy of the back of that card).

LABORATORY TESTING:
Please list the preferred Laboratory Service provider for your insurance. Marist Health Services will use or refer to the preferred provider whenever possible.
Last Name: __________________________ First Name: __________________________ DOB: __________ Date: __________

Gender: __________________________ CWID: __________________________ Cell Phone #: __________________________

FOR STUDENT 18 OR OVER WHEN STARTING SCHOOL:
I hereby consent to treatment by Marist Health Services staff.

Student signature: __________________________

OR

FOR PARENTS OF STUDENTS WHO WILL BE UNDER 18 YEARS OF AGE WHEN STARTING SCHOOL:
(STUDENTS UNDER 18 YEARS OLD CANNOT RECEIVE TREATMENT WITHOUT PARENTAL CONSENT)

I hereby consent for Marist College Health Services to treat the above named student 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: __________________________

Relationship: __________________________

Parents, please note: Parental notification of treatment for illness or injury of any student over 18 years of age is the responsibility of the student. Marist College staff will actively encourage students to inform their parents/guardians of illness, injury, or medical treatment.

OPTIONAL CONSENT TO DISCUSS MEDICAL CONDITION FOR STUDENTS 18 AND OLDER:
I hereby give my consent to Marist College Health Services to discuss my medical condition with my parent(s) or guardian(s), listed below. I understand that I can withdraw this permission at any time.

Parent(s) or Guardian(s):

Name: __________________________ Relationship: __________________________

Name: __________________________ Relationship: __________________________

Student signature: __________________________