ROBERTS WESLEYAN COLLEGE

Dear Student,

Welcome to Roberts Wesleyan College! We are excited to have you on campus soon.

New York State Public Health Law requires students enrolled at institutions of higher education to submit proof of specific vaccines, a health history and a physical. The reverse side of this letter provides examples of how to obtain approved documentation.

International students, student-athletes, students participating in college-sponsored overnight trips, and nursing students are required to carry and supply validation of health insurance coverage by submitting a copy of an insurance ID card or a letter showing the coverage and expiration date. It is highly recommended for students to carry health insurance ID.

Please send your documents directly to the Health Center via mail or fax to 585.594.6920. Due to the significant amount of submissions, the recording process may take up to 2 to 4 days, so it is best to submit your documents as soon as possible. ***The submission deadline is one month before the first class session.***

For more information about the health center services, or to retrieve Health History and Immunization forms for full-time undergrad students, nursing students, student-athletes, and international students, please visit our website at www.roberts.edu /healthcenter.

Should you need assistance, contact the Campus Health Center at 585.594.6360 or healthcenter@roberts.edu.

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 & Immunization form completed by a health care provider
- An official copy of a medical record from your health care provider
- An official copy of childhood school or high school immunization record
- An official copy of the previous college immunization record
- An official copy of employer health record
- An official copy of military health record

All 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 (dated within 5 years) or Meningococcal Meningitis Vaccination Declination Statement completed and signed by the student if he or she did not obtain the meningitis vaccine and elect to waive it at this time.

3. A physical record and other requested vaccines are also required:
   All students must submit a physical record (within a year), varicella vaccines, tuberculin result
   Nursing students must submit a physical record (within a year), Hepatitis B vaccines, varicella vaccines, recent tuberculin screening test result, and flu vaccine (for clinical)
   Student-Athletes MUST have a physical less than six months before the start of sports participation
   International students must submit a physical (within a year), tuberculin screening test result, and varicella vaccines

If you are unable to retrieve any vaccine (immunization) records, there are three alternatives to fulfill the NYSPHL vaccine (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 positive or immune results is 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, obtain a titer (blood) test specifically for measles.
   The measles titer test with the positive or immune results is 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 is acceptable proof.

All students are required to complete the Tuberculin screening form to determine if a tuberculin skin test is required for attendance. Nursing students and international students are required to get a tuberculin skin test before college attendance and annually (if out of country for more than a month).

PLEASE NOTE: New York State Public Health Law requires NYS colleges to excluded non-compliant students from college classes, activities, campus, and dorm residence by a designated date.

ROBERTS WESLEYAN COLLEGE

Health History & Immunization Form for College Enrollment

Academic Year: 2 _____ ✈ Fall semester ✈ Spring semester ✈ Summer semester	
✈ Undergraduate Freshman ✈ Transfer Student ✈ Remit Student ✈ International Student ✈ E.L.I. Student ✈ B.E.L.L. Student ✈ Nursing ✈ Athlete-Student Sport(s) _____	**Office Use Only** **Received:** _____ **Recorded:** _____ **By Staff:** _____
To secure confidentiality, please submit the completed form and documents directly to: 1. Mail to: Health Center Roberts Wesleyan College 2301 Westside Drive, Rochester, NY 14624 2. Email at healthcenter@roberts.edu (at your discretion) 3. Fax (secured line) at 585-594-6920 Incomplete information or unsigned forms will not be processed.	**SUBMISSION DEADLINE** One month before the first class session or sports participation.
Failure to comply with the New York State Public Health Law 2165 & 2167 regulations prevent clearance for attendance.	

Last name: _____ First: _____ Middle Initial:_____

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:

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

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

Insurance Company:_____

Membership/Policy No:_____ Group No:_____

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

RELEASE OF INFORMATION / EMERGENCY CONTACT:

I permit 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 contacted 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 and Immunization 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 necessary. I understand my information, if pertinent, may be shared to facilitate collaboration among the Athletic Department, Campus Security, Counseling Center, Learning Center and Student Life staff to coordinate treatment 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, serious illness or injury, in which parent(s) or guardian(s) may be notified at the discretion of the Health Center 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: _____/_____/_____

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

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					

Comments and/or explanation(s):

Medical History (Answer all questions)	Yes	No	Explain all "yes" answers below or on an additional sheet and attach it.
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 regularly? 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.

Student information:				
Name:			**Date of Physical:**	
Date of Birth:			**Gender:**	
Intercollegiate Sports(s)			**Year in School: FR SO JR SR**	
Examination *(Physical date must be within a year) (Athletic physical date must be within <u>six months</u> of sports participation)*				
Height:	**Weight:**	**BP:**	**Pulse:**	**BMI:**
Vision Corrected: ☼ **Yes** ☼ **No** **L 20/** **R 20/**			**Pupils: Equal / Unequal**	

	Normal	Abnormal or significant findings
General		
Appearance		
HEENT		
Lung		
Heart Murmurs, (auscultation standing, supine)		
Endocrine/Lymph Nodes		
Abdominal		
Genitalia (males only)		
Pulses Radial pulses & Simultaneous femoral		
Neurologic		
Skin		
Musculoskeletal		
Neck/Shoulder/Back		
Arm/Elbow/Wrist/Hand/Fingers		
Leg/Hip/Thigh/Knee		
Ankle/Foot/Toes		

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:

_____

☼ Cleared to participate in a full program college study ☼ Not cleared for college Physical Education study
☼ Cleared for all sports without restrictions
☼ Cleared for all sport without restriction with recommendations for further evaluation or treatment for _____
☼ Not cleared for sports
☼ Pending further evaluation
Reason and recommendations _____

A 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: *(A 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 disease.

Varicella #1 Date: _____/_____/_____ or Varicella disease Date: _____/_____/_____

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

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: _____/_____/_____

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

Rubella (German measles) Date: _____/_____/_____ or Positive/Immune Rubella Titer Date: _____/_____/_____

2. 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.

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

I 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 TEST ***(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 induration *(If positive, chest x-ray report is required)*

RECOMMENDED IMMUNIZATIONS: ***(Hepatitis B 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/Immune Titer Date: _____/_____/_____

IPV/OPV Series completed: yes ____ no ____ FLU Vaccine Date: _____/_____/_____

IPV / OPV Date: _____/_____/_____ COVID Vaccine #1 Date: _____/_____/_____ Pfizer Moderna Janssen

Polio Booster Date: _____/_____/_____ COVID Vaccine #2 Date: _____/_____/_____ Pfizer Moderna

A 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

Part I: Tuberculosis questionnaire *(to be completed by incoming student and physician if required)*

Student Name _____ **Birthdate** _____ / _____ / _____
PLEASE PRINT

Have you ever had close contact with persons known or suspected to have active TB disease? ❑ Yes ❑ No

Do you have a history of positive TB (tuberculin) skin screening test result? ❑ Yes ❑ No

Have you received a BCG vaccination? ❑ Yes ❑ No

Were you born in one of the countries or territories listed below that have a high incidence of active TB disease? (If yes, please CIRCLE the country, below) ❑ Yes ❑ No

Afghanistan
Albania
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladeh
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
Comors
Congo
Côte d'Ivoire
Democratic People's Republic of Korea
The Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
eSwatini
Ethiopia
Fiji
French-Polynesia
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mexico
Micronesia (the Federated States of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Niue
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Portugal Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Sao Tome and Principe
Senegal
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname Swaziland
Tajikistan
Tanzania (the United Republic of)
Thailand
Timor-Leste
Togo
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
Uruguay
Uzbekistan
Vanuatu
Venezuela (the Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

Have you had frequent or prolonged visits* to one or more of the countries or territories listed above with a high prevalence of TB disease? (If yes, CHECK the countries or territories, above)

❑ Yes ❑ No

Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)?

❑ Yes ❑ No

Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease?

❑ Yes ❑ No

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 receive TB testing as soon as possible or at least before 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 travel exposure should be discussed with a health care provider and evaluated.*

_____ _____ / _____ / _____

Student's Signature **Today's Date**

Part II. Clinical Assessment to be completed by a Health Care Provider

Clinicians should review and verify the information in Part I. Persons answering YES to any of the questions in Part I are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA) unless a previous positive test has been documented.

Student Name _____ **Birthdate** _____ / _____ / _____

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 if possible.) ____**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 three 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 an 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:____/____/____ (M D Y) Date Read:____/____/____ (M D Y)

Result:_____mm of induration **Interpretation: positive____negative____

Date Given:____/____/____ (M D Y) Date Read:____/____/____ (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 (include receiving the 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 (leukemia 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 travel exposure should be discussed with a health care provider and evaluated.**

3. T-SPOT TB Test

Single blood test to reduce assay variability and maximize sensitivity. Best for those you were vaccinated with BCG vaccine in the past and immunopsuppressed persons.

Date Tested: ___/____/____ Result: positive_____negative_____
M D Y

4. 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 PREVIOUS or RECENT T-SPOT, TST or IGRA is positive)

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

Part III. Management of Positive TST or IGRA

All 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.

- Infected with HIV
- Recently infected with *M. tuberculosis* (within the past two 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
- Cigarette smokers and persons who abuse drugs and/or alcohol

____The student agrees to receive treatment

____The student declines treatment at this time

A 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:

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence per 100,000 population. For future updates, refer to http://www.who.int/tb/country/en/.