HARTWICK COLLEGE
est. 1797

Certificate of Medical Examination

To be completed by student and parent or guardian. Please print.
RETURN ENTIRE PACKET TOGETHER BY JULY 15 (fall admittance), **DECEMBER 1** (J Term admittance), **OR JANUARY 2** (spring admittance). Keep a copy for your records.
Questions? Call Perrella Health Center at 607-431-4120.

Mail to: Perrella Health Center, Hartwick College, P.O. Box 4020, Oneonta, NY 13820
Fax: 607-431-4124 | **e-mail:** healthcenter@hartwick.edu

Information on this form is confidential and solely for the use of the Health Center. No information will be released without the student's consent and it in no way will affect the student's college standing. The purpose of this form is to help the Health Center staff render the student effective aid and medical care.

Nursing Major ☐ Yes ☐ No Intercollegiate Athlete ☐ Yes Sport(s) _____ ☐ No

_____ ____/____/____ _____
Student name (last, first, middle) Date of Birth Student college ID #

_____
Permanent home address (street, city, state, zip)

_____ _____ _____
Home phone number Parent cell phone number Student cell phone number

_____ _____
Parent(s) or guardian(s) In Case of Emergency, Contact

_____ _____
Address (street, city, state, zip) Relationship

_____ _____
Phone number(s) Phone number(s)

_____ _____ ____/____/____
Health insurance company Subscriber's name Date of Birth

_____
Insurance company address (street, city, state, zip)

_____ _____
Policy number Group number

Contact your insurance company to verify coverage in the Oneonta area.

Does your insurance company require a student to get prior approval before obtaining services rendered outside the Perrella Wellness Center? ☐ Yes ☐ No

Health insurance is required for all full-time students. You must enroll in a policy made available by the College or waive the Hartwick insurance with proof of coverage. An on-line health insurance election form is available starting in June. It must be submitted electronically by all students.

Medical Treatment Permission Form

All registered students and parent/guardian of students under 18 years of age must sign.

I I hereby give permission to the Hartwick College medical/nursing staff to examine and treat the student named on this form for problems/injuries while a student at Hartwick College. In the event of time constraints, if unable to indicate consent, or if a minor parent/guardian is unable to be reached, I hereby give permission for the Perrella Staff to obtain consultative care that may include hospitalization, anesthesia, surgery, and/or other medical treatment. I understand that I have the right to revoke consent at any time. If I am enrolled in the nursing major, I authorize documentation regarding my annual physical, tuberculosis screening, and immunization status to be released to the nursing department and any clinical facilities where I will be a student.

_____ ____/____/____
Student signature **Date**

_____ ____/____/____
Parent/guardian signature (if student under 18 years) **Date**

HARTWICK COLLEGE

Family and Student Medical History

To be completed by student and reviewed by health care provider.

_____ ____/____/____ _____

Student Name *Date of Birth* *Gender*

Family Medical History

If any of your immediate relatives have or have had the diseases listed, check the corresponding box (includes parents, grandparents, siblings, children).

- ☐ Alcoholism
- ☐ Anemia
- ☐ Bleeding tendency
- ☐ Cancer
- ☐ Death in family under 50
- ☐ Diabetes
- ☐ Heart disease
- ☐ Hereditary disorder
- ☐ High blood pressure
- ☐ Mental illness
- ☐ Migraines
- ☐ Obesity
- ☐ Stroke
- ☐ Tuberculosis
- ☐ None of the above

Student Medical History

Indicate past or present.

Intercollegiate athletes are required to complete pre-participation history form and physical exam form - see pages 7 and 8.

- ☐ ADD/ADHD
- ☐ Alcoholism
- ☐ Allergic rhinitis
- ☐ Anemia
- ☐ Aspergers/Autism
- ☐ Asthma
- ☐ Anxiety/panic attacks
- ☐ Bleeding trait
- ☐ Cancer or malignancy
- ☐ Chicken pox: date____/____/____
- ☐ Concussion: date____/____/____
  date____/____/____
- ☐ Counseling for depression
- ☐ Diabetes
- ☐ Eating disorders
- ☐ History of heart disease/ heart problems
- ☐ Hypertension (elevated blood pressure)
- ☐ Infectious mononucleosis
- ☐ Inflammatory bowel disease
- ☐ Joint injury
- ☐ Migraines
- ☐ Pelvic infection
- ☐ Peptic ulcer
- ☐ Phlebitis
- ☐ Pregnancies/abortions
- ☐ Recurrent ear infections
- ☐ Recurrent throat infections
- ☐ Rheumatic fever
- ☐ Seizure disorders (epilepsy)
- ☐ Sexually transmitted disease
- ☐ Spine or neck injury
- ☐ Substance abuse
- ☐ Tuberculosis
- ☐ Urinary tract infections
- ☐ Viral hepatitis
- ☐ Other:_____
  _____
  _____
- ☐ None of the above

☐ Covid 19: date of diagnosis ____/____/____ **Athletes MUST discuss positive diagnosis with Sports Medicine prior to arriving on campus.**

☐ Surgeries (please list)

_____Date: ____/____/____

_____Date: ____/____/____

☐ Present medications and dosage (Please list)

_____

_____

Medical indication for special dietary accommodations? ☐ Yes ☐ No

Specify:_____

Contact Perrella Health Center at 607-431-4120 re: accommodations available.

Special academic accommodations needed? Please specify accommodations needed and contact the Center for Student Success at 607-431-4195 to establish your plan. _____

PLEASE INDICATE ANY ALLERGIES:

☐ No known medication allergies

- ☐ Medications (specify)_____
- ☐ Environmental (specify)_____
- ☐ Food (specify) _____
- ☐ Other (specify) _____

HARTWICK COLLEGE
est. 1797

Physical Examination Form

Must be completed by physician, nurse practitioner, or physician's assistant. Please print.
RETURN ENTIRE PACKET TOGETHER BY JULY 15 (fall admittance), **DECEMBER 1** (J Term admittance), **OR JANUARY 2** (spring admittance). Keep a copy for your records.
Questions? Call Perrella Health Center at 607-431-4120.

Mail to: Perrella Health Center, Hartwick College, P.O. Box 4020, Oneonta, NY 13820
Fax: 607-431-4124 | **e-mail:** healthcenter@hartwick.edu

WE REQUIRE THAT THE PHYSICAL EXAMINATION BE COMPLETED WITHIN 12 MONTHS OF THE START OF THE ACADEMIC YEAR.
ATHLETE PHYSICALS MUST BE COMPLETED WITHIN 6 MONTHS OF FIRST PARTICIPATION.

_____ ____/____/____ ____/____/____
Student name Date of Birth Date of Exam

Gender: _____
Age: _____
Blood pressure: _____
Pulse: _____
Height: _____
Weight: _____
Vision: _____
Far: Right 20/ _____
Corr. to 20/ _____
Far: Left 20/ _____
Corr. to 20/ _____

Any operations, serious injuries, or serious illness not noted at right?

_____

_____

Restrictions (specify):

Clinical Evaluation	Normal	Abnormal	Please comment on all abnormal
1. Skin			
2. HEENT			
3. Lymphatic			
4. Respiratory			
5. Cardiovascular			
6. Musculoskeletal			
7. Hernia			
8. Abdomen			
9. GU			
10. GYN date last pap smear: ____/____/____			
11. Neurological			
12. Orthopaedic A. Shoulders	L _____ R _____	L _____ R _____	
B. Knees	L _____ R _____	L _____ R _____	
C. Ankles	L _____ R _____	L _____ R _____	
13. History of Covid 19	Date of diagnosis: ____/____/____		

_____

_____

By signing below I acknowledge review of the medical history pg 2 and completion of physical examination form. This student is able to engage in required physical education program and contact sports unless otherwise indicated. If a nursing major, student is medically cleared to wear respiratory protection and is in satisfactory condition to care for clients.

_____ _____
Name of healthcare provider (print) **Telephone**

_____
Address (street, city, state, zip)

_____ ____/____/____
Signature of healthcare provider **Date**

HARTWICK COLLEGE

Tuberculosis Risk Assessment

Must be completed by health care provider.

_____ ____/____/____

Student Name *Date of Birth*

Clinicians should review and verify the information below. Persons for whom YES is answered in Part A are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented. Per current CDC guidelines history of BCG vaccination is not a contraindication for a TST.

History of positive TST or IGRA blood test? (If yes, document in Part B) ☐ Yes ☐ No

History of BCG vaccination? (If yes, Consider IGRA if possible) ☐ Yes ☐ No

A: Required For ALL Students

- Has this student been in close contact with anyone with active TB? ☐ Yes ☐ No
- Was this student born in or has this student lived in or visited any countries that are **NOT** on the list below for more than one month?

  ☐ Yes ☐ No Country:_____
- Does the student have persistent cough with night sweats, loss of weight, fatigue, or fever? ☐ Yes ☐ No

If you answer yes to any of these questions, complete section B.

The countries listed below are without epidemic TB.

AMERICAN REGION: USA, Bermuda, British Virgin Islands, Canada, Cayman Islands, Chile, Costa Rica, Cuba, Jamaica, Saint Kitts and Nevis, Puerto Rico, Saint Lucia, Trinidad, Virgin Islands

EUROPEAN REGION: Albania, Belgium, Cyprus, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Slovakia, Slovenia, Spain, Sweden, Switzerland, United Kingdom

WESTERN PACIFIC REGION: American Samoa, Australia, New Zealand

MIDDLE EAST REGION: Israel, Jordan, Lebanon, United Arab Emirates

If the student is from one of the above regions, skip Section B. If not, Section B must be completed.

B: Required For Any Students From Regions NOT Listed Above

Tuberculosis screening test (TST):
Must submit date placed, date read, and induration in mm even if 0. May submit attached copy of Quantiferon Gold blood test instead of TST.

Date placed ____/____/____

Date read ____/____/____

TST result: _____ mm

If TST (>/= 10 mm in most cases) or Quantiferon is positive,
you must submit copy of CXR report.

- Treatment received for positive TST? ☐ Yes ☐ No
- Treatment was discussed and declined? ☐ Yes ☐ No

CXR result _____ Date ____/____/____

Medication taken (if any) _____

and dates taken: ____/____/____ to ____/____/____

▶ ***Nursing majors must complete 2 step TST on pg. 5***

_____ _____ ____/____/____

REQUIRED: Healthcare provider signature **Date**

_____ _____

Address (street, city, state, zip) **Telephone**

HARTWICK COLLEGE

Immunization Record

Must be completed by health care provider, or attach official immunization record.

_____ _____/_____/_____

Student Name *Date of Birth*

Required: Part I , A-E

A. M.M.R. (Measles, Mumps, Rubella) Two doses given after age 1-year required by NYS PHL 2165.

Dose 1: _____/_____/_____ Dose 2: _____/_____/_____

(minimum 28 days apart)

B. DPT (Diphtheria/Pertussis/Tetanus)

Series completed: _____/_____/_____

Booster—Tdap within last 10

years: _____/_____/_____

C. Polio: Completed primary series of polio immunization:

Type of vaccine: _____

Last booster: _____/_____/_____

D. Meningococcal tetravalent conjugate

BOOSTER DOSE REQUIRED WITHIN 5 YEARS OF START OF ACADEMIC YEAR.

(A.C.Y.W.) ☐ Menactra or ☐ Menveo

(Include all dates recieved)

Date: _____/_____/_____ Date: _____/_____/_____

E. SARS-CoV-2 (COVID-19)

Brand: _____

Date: _____/_____/_____ Date: _____/_____/_____

(Copy of vaccine card should be included with forms)

Recommended: Part 2

A. Hepatitis B

Dose 1: _____/_____/_____

Dose 2: _____/_____/_____

Dose 3: _____/_____/_____

B. Varicella (chicken pox)

Dose 1: _____/_____/_____ Dose 2: _____/_____/_____

OR date of disease: _____/_____/_____

C. Quadrivalent Human Papillomavirus vaccine (HPV)

Dose 1: _____/_____/_____

Dose 2: _____/_____/_____

Dose 3: _____/_____/_____

D. Meningitis B vacine (Bexsero or Trumenba)

Dose 1: _____/_____/_____ Dose 2: _____/_____/_____

Proof of immunity to measles, mumps, and rubella is required by NYS Health Law for all students registered for six or more credits. Medical exemptions are possible. Contact the Perrella Wellness Center at 607-431-4120 for questions or more information.

Proof of COVID-19 vaccination is required by Hartwick College. Requests for accommodation will be reviewed per the Covid 19 vaccination policy.

MENINGITIS RESPONSE FORM MUST ALSO BE COMPLETED.

REQUIRED FOR NURSING MAJORS ONLY

A. Hepatitis B vaccine

Dose 1: _____/_____/_____

Dose 2: _____/_____/_____

Dose 3: _____/_____/_____

OR Positive titer date:

_____/_____/_____

B. Varicella (chicken pox)

History of disease?

Yes, date required:

_____/_____/_____

No, immunization dates:

Dose 1: _____/_____/_____

Dose 2: _____/_____/_____

OR Positive titer date:

_____/_____/_____

C. Initial 2-step Tuberculosis screening test (TST)

(if first step negative, give second test 1-3 weeks later)

Step 1. TST date planted: _____/_____/_____ date read: _____/_____/_____

Results _____ mm induration ☐ Pos. ☐ Neg.

Step 2. TST date planted: _____/_____/_____ date read: _____/_____/_____

Results_____ mm induration ☐ Pos. ☐ Neg.

OR Quantiferon Gold: Results: _____ (attach copy of result)

If test is positive or there is a history of positive TST, chest x-ray is required.

Date: _____/_____/_____ Results: _____

Attach a copy of chest x-ray results. Attach plan for prophylactic therapy if chest x-ray is positive.

_____ _____/_____/_____

REQUIRED: Healthcare provider signature **Date**

_____ _____

Address (street, city, state, zip) **Telephone**

HARTWICK COLLEGE

Meningococcal 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 Hartwick College.

Check one box and sign below.

I have (for students under the age of 18: My child has):

☐ had 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.*]

☐ read, or have had explained to me, the information regarding meningococcal disease. I (my child) will obtain immunization against meningococcal disease **within 30 days** from my private health care provider or Hartwick College.

☐ 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.

☐ Completed the two dose series of Quadrivalent meningococcal vaccine. My last dose was greater than 5 years ago. I have read, or have had explained to me, the information regarding meningococcal disease. I understand the risks and I have decided that I (my child) **will decline** to recieve a booster dose of the immunization against meningococcal disease.

_____ _____/_____/_____
Signed (by Student) OR (Parent/Guardian if student is a minor) **Date**

_____ _____/_____/_____
Print Student's name (last, first, middle) **Student Date of Birth**

_____ _____
Student email address **Student college ID #**

_____
Student mailing address (street, city, state, zip)

_____
Student phone number

HARTWICK COLLEGE

Health Information Use and Disclosure

To be completed by student and parent or guardian.

_____ _____/_____/_____

Student Name *Date of Birth*

This form authorizes the use and disclosure of individually identifiable health information to the Bassett Healthcare Network of Providers.

The Perrella Health Center at Hartwick College utilizes an electronic medical record-keeping system (EMR) in affiliation with the Bassett Healthcare Network. This system allows the Perrella Health Center and/or the Bassett Healthcare Network of Providers to access different components of any patient's "chart" and also provide up-to-date information to any provider in the Bassett Healthcare Network who might see patients on an emergency basis and/or when our clinic is closed. The Perrella Health Center also can promptly access test results as they are completed, bypassing clerical turnaround times. EMR is a welcome addition at the Perrella Health Center as we strive to provide efficient, comprehensive healthcare to our students.

1. I authorize the use and/or disclosure of my health information as described below.

2. My health information will be shared only between the Perrella Health Center and the Bassett Healthcare Network of Providers to facilitate continuity of care in the event I require treatment by the Fox Hospital Emergency Department or FoxNow walk-in clinic. It also will be available to Bassett Network affiliated specialists if I should require their services. This also will enable the Perrella Health Center to access my test results (laboratory tests, x-rays, cultures, etc.) in a timely manner in order to expedite my care.

3. I understand that the information in my health record may include information regarding the use of drug and alcohol treatment services, HIV/AIDS treatment, mental health services, reproductive health services, and treatment for sexually transmitted diseases.

   Note: Psychotherapy records from our College counselors, other than referrals to our providers, may be used/disclosed only pursuant to a separate signed authorization pertaining only to psychotherapy records.

4. I understand that the information I authorize to be used or disclosed may be used only within the Bassett Healthcare Network of providers, but may be subject to re-disclosure. Re-disclosure designates that the information is no longer protected under federal privacy regulations. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

5. I understand that this authorization is subject to revocation at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Perrella Health Center at Hartwick College. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the date of graduation or other official permanent separation from the College.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization, but do acknowledge that by refusing to authorize, communication may be delayed. I understand that I need not sign this form to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided by the CFR 164.524. If I have any questions about disclosure of my health information, I can contact the director of the Perrella Health Center by calling 607-431-4120.

Student name (please print)	**Signature of student (or person authorized to consent for student)**	**Date signed** _____/_____/_____
Parent/guardian name if student is under 18 years of age (please print)	**Signature of Parent/guardian**	**Date signed** _____/_____/_____
Signature of staff person at Perrella Health Center	**Title**	**Date signed** _____/_____/_____

HARTWICK COLLEGE

History Form | Intercollegiate Athletes Only

Date of exam must be kept within 12 calendar months to maintain eligibility.

Student Name _____ *Date of Exam* _____/_____/_____

Sport(s) _____ *DOB* _____/_____/_____ *Gender* _____

Form must be completed and returned to Perrella Health Center at least 2 weeks prior to sports participation. NO EXCEPTIONS.
Questions? Call Perrella Wellness Center at: 607-431-4120 | Fax: 607-431-4124 | email: healthcenter@hartwick.edu

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other:	☐	☐
3. Have you ever spent the night in the hospital?	☐	☐
4. Have you ever had surgery?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?	☐	☐
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	☐	☐
7. Does your heart ever race or skip beats (irregular beats) during exercise?	☐	☐
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease ☐ Other: _____	☐	☐
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)	☐	☐
10. Do you get lightheaded or feel more short of breath than expected during exercise?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?	☐	☐
12. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?	☐	☐
13. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?	☐	☐
14. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?	☐	☐
BONE AND JOINT QUESTIONS	**Yes**	**No**
15. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?	☐	☐
16. Have you ever had any broken or fractured bones or dislocated joints?	☐	☐
17. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?	☐	☐
18. Have you ever had a stress fracture?	☐	☐
19. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)	☐	☐
20. Do you regularly use a brace, orthotics, or other assistive device?	☐	☐
21. Do you have a bone, muscle, or joint injury that bothers you?	☐	☐

OTHER MEDICAL QUESTIONS	Yes	No
22. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
23. Have you ever used an inhaler or taken asthma medicine?	☐	☐
24. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	☐	☐
25. Do you have groin pain or a painful bulge or hernia in the groin area?	☐	☐
26. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
27. Do you have any rashes, pressure sores, or other skin problems? (i.e. MRSA)	☐	☐
28. Have you ever had a head injury or concussion?	☐	☐
29. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?	☐	☐
30. Do you have a history of seizure disorder?	☐	☐
31. Do you have headaches with exercise?	☐	☐
32. Have you ever become ill while exercising in the heat?	☐	☐
33. Do you get frequent muscle cramps when exercising?	☐	☐
34. Do you or someone in your family have sickle cell trait or disease?	☐	☐
35. Have you had any problems with your eyes or vision?	☐	☐
36. Have you had any eye injuries?	☐	☐
37. Do you wear glasses or contact lenses?	☐	☐
38. Are you trying to or has anyone recommended that you gain or lose weight?	☐	☐
39. Are you on a special diet or do you avoid certain types of foods?	☐	☐
40. Have you ever had an eating disorder?	☐	☐
FEMALES ONLY		
41. How many periods have you had in the last 12 months? _____		
MEDICINES AND ALLERGIES	**Yes**	**No**
Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.		
_____		
_____		
_____		
_____		
42. Do you have any allergies?	☐	☐
If yes, please identify specific allergy below. ☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects		
SARS-CoV-2 (COVID-19)		
43. Have you had COVID-19? Date of diagnosis: _____/_____/_____ Were you cleared for athletics post Covid 19?	☐ ☐	☐ ☐

EXPLANATION AND DATES FOR ALL "YES" ANSWERS HERE _____

I hereby state that, to the best of my knowledge, the answers to the above questions are complete and correct. In signing this document, I give permission for my sports history and physical forms, updates regarding injury or illness, and information regarding my medical clearance for athletic participation may be shared with my coach, the athletic training staff, and the athletic administrative staff as deemed appropriate by the Perrella medical staff.

_____ _____/_____/_____
Signature of athlete **Date**

_____ _____/_____/_____
Signature of parent/guardian (if under 18) **Date**

HARTWICK COLLEGE

Physical Examination Form | Intercollegiate Athletes Only

Must be completed by health care provider. Date of exam must be kept within 12 calendar months to maintain eligibility. **The initial exam must be completed within 6 months of first participation in athletics at Hartwick College.**

_____ _____/_____/_____ _____/_____/_____

Student Name *Date of Birth* *Date of Exam*

Form must be completed and returned to Perrella Health Center at least 2 weeks prior to sports participation. NO EXCEPTIONS.

Questions? Call Perrella Wellness Center at:607-431-4120 | Fax: 607-431-4124 | email: healthcenter@hartwick.edu

EXAMINATION

Height Weight BP / (/) Pulse

Vision R 20/ L 20/ Corrected ☐ Yes ☐ No

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart [a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic [c]		
MUSCULOSKELETAL		
Neck		
Back		
Upper extremities		
Lower extremities		
Functional • Duck-walk, single leg hop		

SARS-CoV-2 (COVID-19)

Has this athlete been diagnosed with COVID-19? ☐ Yes ☐ No If yes, date of infection: _____/_____/_____

List any post diagnosis athletic clearance performed, with date(s): _____

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?

a Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

b Consider GU exam if in private setting. Having third party present is recommended.

c Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

I have examined the above-named student, reviewed the History Form, and completed the preparticipation physical evaluation. This athlete is cleared to practice and participate in the sport(s) as outlined above without restriction **unless noted below**.

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

☐ Not cleared: ☐ Pending further evaluation

☐ For any sports

☐ For certain sports _____

Reason _____

Recommendations _____

_____

If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

_____ _____/_____/_____

Name of healthcare provider (print or stamp) **Date**

_____ _____ _____

Address **Phone**

_____

Signature of healthcare provider

HARTWICK COLLEGE
est. 1797

Dear Student and/or Family Members:

As the college health service director at Hartwick College, I am writing to inform you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis. New York State Public Health Law (NYS PHL) §2167 requires institutions, including colleges and universities, to distribute information about meningococcal disease and vaccine to all students meeting the enrollment criteria, whether they live on or off campus.

Hartwick College is required to maintain a record of the following for each student:

- A response to receipt of meningococcal disease and vaccine information signed by the student or student's parent or guardian (if the student is a minor)
  AND EITHER
- A record of meningococcal immunization **within the past 5 years**; OR
- An acknowledgement of meningococcal disease risks and refusal of meningococcal immunization signed by the student or student's parent or guardian.

Meningococcal disease is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. Meningococcal disease can cause serious illnesses such as infection of the lining of the brain and spinal column (meningitis) or blood infections (sepsis). The disease strikes quickly and can lead to severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even lead to death.

Meningococcal disease can be easily spread from person-to-person by coughing, sharing beverages or eating utensils, kissing, or spending time in close contact with someone who is sick or who carries the bacteria. People can spread the bacteria that causes meningococcal disease even before they know they are sick. There have been several outbreaks of meningococcal disease at college campuses across the United States.

The single best way to prevent meningococcal disease is to be vaccinated. The meningococcal ACWY (MenACWY) vaccine protects against four major strains of bacteria which cause about two-thirds of meningococcal disease in the United States (U.S.). The MenACWY vaccine is recommended for all U.S. teenagers and young adults up to age 21 years. Protection from the MenACWY vaccine is estimated to last about 3 to 5 years, so young adults who received the MenACWY vaccine before their 16th birthday should get a booster dose before entering college. The meningococcal B (MenB) vaccine protects against a fifth type of meningococcal disease, which accounts for about one-third of cases in the U.S. Young adults aged 16 through 23 years may choose to receive the MenB vaccine series. They should discuss the MenB vaccine with a healthcare provider.

All private insurance plans not grandfathered under the Affordable Care Act are required to cover the cost of MenACWY and MenB vaccines. Contact your health insurance plan to determine whether it covers MenACWY and MenB vaccines. The federal Vaccines for Children (VFC) and NYS Vaccines for Adults (VFA) programs will cover both MenACWY and MenB vaccines for children and adults who have no health

insurance or whose health insurance does not cover these vaccines, as well as for children less than 19 years of age who are American Indian or Alaska Native or eligible for Medicaid or Child Health Plus.

Hartwick College Student Health Center can provide the MenACWY vaccine (Menactra) with an appointment at a cost of $120 paid to the Perrella Health Center in cash or check or billed to the student's account. A receipt will be provided which the student/parent may submit to their private insurance company. Hartwick College does not directly bill private insurance companies for the cost of the vaccine. Those students with the College Student Health Insurance Plan are able to have the cost fully covered by that plan. Hartwick College does not participate in the VFA or the VFA program. Students who wish to have the vaccine are encouraged to make arrangements with their own primary care provider. Those wishing to make arrangements to receive the vaccine after arriving at Hartwick College should contact Perrella Health Center for assistance in locating a local provider who can administer the vaccine or setting up an appointment with the Otsego County Health Department for immunization if they are not enrolled in the College Health Insurance Plan.

Please carefully review the attached Meningococcal Disease Fact Sheet. It is also available on the New York State Department of Health website at www.health.ny.gov/publications/2168.pdf. **Complete the Meningococcal Vaccination Response Form and return it to Hartwick College with your mandatory health documents.**

NOTE: PER PUBLIC HEALTH LAW, NO INSTITUTION SHOULD PERMIT ANY STUDENT TO ATTEND THE INSTITUTION IN EXCESS OF 30 DAYS WITHOUT COMPLYING WITH THIS LAW.

To learn more about meningococcal disease and the vaccine, please feel free to contact our health service and/or consult your child's physician. You can also find information about the disease on the Centers for Disease Control and Prevention website at www.cdc.gov/meningococcal/.

Sincerely,

Amy Gardner

Amy Gardner FNP-C
Hartwick College

Meningococcal Disease

Meningococcal Disease Fact Sheet

(www.health.ny.gov/publications/2168/)

What is meningococcal disease?

Meningococcal disease is caused by bacteria called Neisseria meningitidis. It can lead to serious blood infections. When the linings of the brain and spinal cord become infected, it is called meningitis. The disease strikes quickly and can have serious complications, including death.

Anyone can get meningococcal disease. Some people are at higher risk. This disease occurs more often in people who are:

• Teenagers or young adults
• Infants younger than one year of age
• Living in crowded settings, such as college dormitories or military barracks
• Traveling to areas outside of the United States, such as the "meningitis belt" in Africa
• Living with a damaged spleen or no spleen or have sickle cell disease
• Being treated with the medication Soliris® or, who have complement component deficiency (an inherited immune disorder)
• Exposed during an outbreak
• Working with meningococcal bacteria in a laboratory

What are the symptoms?

Symptoms appear suddenly – usually 3 to 4 days after a person is infected. It can take up to 10 days to develop symptoms.

Symptoms may include:

• A sudden high fever
• Headache
• Stiff neck (meningitis)
• Nausea and vomiting
• Red-purple skin rash
• Weakness and feeling very ill
• Eyes sensitive to light

How is meningococcal disease spread?

It spreads from person-to-person by coughing or coming into close or lengthy contact with someone who is sick or who carries the bacteria. Contact includes kissing, sharing drinks, or living together. Up to one in 10 people carry meningococcal bacteria in their nose or throat without getting sick.

Is there treatment?

Early diagnosis of meningococcal disease is very important. If it is caught early, meningococcal disease can be treated with antibiotics. But, sometimes the infection has caused too much damage for antibiotics to prevent death or serious long-term problems. Most people need to be cared for in a hospital due to serious, life-threatening infections.

What are the complications?

Ten to fifteen percent of those who get meningococcal disease die. Among survivors, as many as one in five will have permanent disabilities. Complications include:

- Hearing loss
- Brain damage
- Kidney damage
- Limb amputations

What should I do if I or someone I love is exposed?
If you are in close contact with a person with meningococcal disease, talk with your healthcare provider about the risk to you and your family. They can prescribe an antibiotic to prevent the disease.

What is the best way to prevent meningococcal disease?
The single best way to prevent this disease is to be vaccinated. Vaccines are available for people 6 weeks of age and older. Various vaccines offer protection against the five major strains of bacteria that cause meningococcal disease:

- All teenagers should receive two doses of vaccine against strains A, C, W and Y, also known as MenACWY or MCV4 vaccine. The first dose is given at 11 to 12 years of age, and the second dose (booster) at 16 years.
    - It is very important that teens receive the booster dose at age 16 years in order to protect them through the years when they are at greatest risk of meningococcal disease.
- Teens and young adults can also be vaccinated against the "B" strain, also known as MenB vaccine. Talk to your healthcare provider about whether they recommend vaccine against the "B" strain.
- Others who should receive meningococcal vaccines include: o Infants, children and adults with certain medical conditions
    - People exposed during an outbreak
    - Travelers to the "meningitis belt" of sub-Saharan Africa
    - Military recruits

Please speak with your healthcare provider if you may be at increased risk.

Who should not be vaccinated?

- Some people should not get meningococcal vaccine or they should wait.
- Tell your doctor if you have any severe allergies. Anyone who has ever had a severe allergic reaction to a previous dose of meningococcal vaccine should not get another dose of the vaccine. Anyone who has a severe allergy to any component in the vaccine should not get the vaccine.
- Anyone who is moderately or severely ill at the time the shot is scheduled should probably wait until they are better. People with a mild illness can usually get the vaccine.

What are the meningococcal vaccine requirements for school attendance?

- For grades 7 through 9 in school year 2018-19: one dose of MenACWY vaccine. With each new school year, this requirement will move up a grade until students in grades 7 through 11 will all be required to have one dose of MenACWY vaccine to attend school
    - 2019-20: grades 7, 8, 9, and 10
    - 2020-21 and later years: grades 7, 8, 9, 10, and 11
    - For grade 12: two doses of MenACWY vaccine.
        - The second dose needs to be given on or after the 16th birthday.
    - Teens who received their first dose on or after their 16th birthday do not need another dose.

Additional Resources:
• Meningococcal Disease – CDC (cdc.gov/meningococcal/index.html)
• Meningococcal Vaccination – CDC (cdc.gov/vaccines/vpd/mening/index.html)
• Meningococcal ACIP Vaccine Recommendations (cdc.gov/vaccines/hcp/acip-recs/vacc-specific/mening.html)
• Travel and Meningococcal Disease (wwwnc.cdc.gov/travel/diseases/meningococcal-disease)
• Information about Vaccine-Preventable Diseases (health.ny.gov/prevention/immunization/)