Bard Medical History Information

MUST BE COMPLETED AND RETURNED

Please note: Each entering student is required to complete all sections of this document and return it to the Student Health Service. The Physical Examination and Immunization forms must be completed and signed by a nonparental health care provider. *This information is available to the Bard College Student Health and Counseling Services only and is strictly confidential.* **Information will not be released without the knowledge and written consent of the student.**
PLEASE PRINT LEGIBLY, USING BLUE OR BLACK INK ONLY.

Name ______________________________ Date ________
Last First Middle

E-mail ______________________________

Date of birth ________ ☐ Male ☐ Female ☐ Other Telephone ______________________________
home cell

Home address ______________________________
Street City State Zip Country

Entering as: ☐ Freshman ☐ Transfer/Level (i.e.: Soph., Jr., Sr.) _______ ☐ Graduate/Program name ____________________

Person to contact in case of emergency:

Name ______________________________ Relationship ________________

Address ______________________________
Street City State Zip Country

Telephone ______________________________
home work cell

E-mail ______________________________

Personal History

Please indicate whether you have or have ever had any of the following. (Give details for each "yes" in the space provided,* or attach a separate sheet if needed.)

	Yes	No		Yes	No		Yes	No
Head injury/concussion			Stomach/intestinal problems			Anorexia/bulimia		
Seizure disorder			Hepatitis			Tumor/cancer		
Recurrent headaches/migraines			Kidney disease			Other chronic illness		
Ear/nose/throat problems			Bladder infections			History of surgery		
Sinusitis			Back problem			Overnight hospitalization		
Eye disease			Bleeding disorder			Women:		
Hearing loss			Clotting disorder			Absent period		
Asthma			Anemia			Severe cramps		
Hospitalization w/asthma			Diabetes			Allergies		
Recurrent bronchitis			Insulin dependent			Food		
Heart problems			Thyroid disorder			Bees		
Heart murmur			Mononucleosis			Other		
High blood pressure			Anxiety/depression					
High cholesterol			Insomnia					

Preferred Pronoun ______________________________

Attach a recent photo of yourself here.

* Use this space to explain any answers from personal history.

(continued)

Please return this form to:
Student Health Service, Bard College, PO Box 5000, Annandale-on-Hudson, NY 12504-5000
Telephone: 845-758-7433 **Fax:** 845-758-7437 **E-mail:** healthservice@bard.edu **Website:** www.bard.edu

Medical History Continued

Name Date of birth Date

Has your physical activity been restricted due to illness or injury—athletic or other—in the last five years? Explain.

Have you received treatment or counseling for an emotional or psychiatric problem, or for an eating disorder?
If yes, please list diagnosis, dates, treatment, and current status.

What medications do you take on a regular basis? List name(s), dose(s), and prescriber.

Are you allergic to any medications? Please list. What are the reactions?

Do you: Smoke? ☐ No ☐ Yes How much and for how long? ____________________
Drink alcohol? ☐ No ☐ Yes How much and for how long? ____________________
Use drugs? ☐ No ☐ Yes How much and for how long? ____________________

Family History

If any of your immediate family (parent, sibling, grandparent) had/have the following, please indicate below and describe in the additional space* provided.

	Age	State of health	Occupation	Age at death	Cause
Father					
Mother					
Sibling					
Sibling					
Sibling					
Sibling					
Sibling					

	Yes	No	Relationship
Cancer			
Diabetes			
Died suddenly under age 50			
Heart disease			
High blood pressure			
Gastrointestinal disorder			
Asthma			
Seizures			
Alcoholism/drug addiction			
Depression			
Mental illness			
Other chronic illnesses			

* Explain "yes" answers from family history here:

I affirm that the information provided regarding my personal health and family history is complete and accurate.

Student signature Date

Students under 18 years of age must have a parent or guardian sign below.

I affirm that the information provided regarding the personal health of my son/daughter and family is complete and accurate.

Parent/Guardian signature Relationship Date

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Bard Physical Examination and Immunization Record

A physical exam within the last 12 months is an admission requirement.

Student name ______________________ Date ______________________

☐ Male ☐ Female ☐ Transitioning (please describe) ______________________

Date of birth ______________________ Date of examination ______________________

Allergies ______________________

Height ______ inches Weight ______ lbs. ☐ Underweight ☐ Overweight BMI ________

BP ______/______ Pulse ______/min.

Visual activity	OD: ______ near ______ far		Corrected: OD: ______ near ______ far	
	OS: ______ near ______ far		Corrected: OS: ______ near ______ far	
Head	☐ Normal	☐ Abnormal (describe)	______________________	
Eyes	☐ Normal	☐ Abnormal (describe)	______________________	
Ears	☐ Normal	☐ Abnormal (describe)	______________________	
Nose	☐ Normal	☐ Abnormal (describe)	______________________	
Throat	☐ Normal	☐ Abnormal (describe)	______________________	
Neck	☐ Normal	☐ Abnormal (describe)	______________________	
Chest	☐ Normal	☐ Abnormal (describe)	______________________	
Lungs	☐ Normal	☐ Abnormal (describe)	______________________	
Heart	☐ Normal	☐ Abnormal (describe)	______________________	
Abdomen	☐ Normal	☐ Abnormal (describe)	______________________	
Genitalia	☐ Normal	☐ Abnormal (describe)	______________________	
Skin	☐ Normal	☐ Abnormal (describe)	______________________	
Musculoskeletal	☐ Normal	☐ Abnormal (describe)	______________________	
Neurological	☐ Normal	☐ Abnormal (describe)	______________________	

LABS: Urinalysis: ______________________ CMP (optional): ______________________

CBC: __________ Hct: __________ Hb: __________ Other: __________

Please describe any significant illnesses, injuries, or hospitalizations in this patient's history.

Please submit a treatment plan for BMI below 18.5.

Please comment on any physical or emotional problems that the Bard College Student Health and Counseling Services should be aware of regarding this patient, including past history, medications, and current treatments. Students currently taking medication for an emotional condition and/or learning differences (including attention deficit disorder) should make arrangements to continue to have the medication monitored by the prescribing physician/psychiatrist at home or transfer to an off-campus physician/psychiatrist in the Bard College area.

How long have you known this patient? ______________________

Provider name ______________________ Signature ______________________

Address ______________________ Date ______________________

Telephone ______________________ Fax ______________________ License # ______________________

(continued)

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Telephone: 845-758-7433 **Fax:** 845-758-7437 **E-mail:** healthservice@bard.edu **Website:** www.bard.edu

Bard Immunization Record

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Student name ______________________ Date of birth ______________ Date ____________

New York State law mandates that all students born after January 1, 1957, must show proof of immunity to measles, mumps, and rubella. Students will *not be allowed to register* for classes if this information is not provided to Bard College. To be completed and signed by a nonparental health-care provider. All information must be in English.

Part I Required Vaccinations

mo/day/year

A. MMR (measles, mumps, rubella) 2 doses required (Skip to E if A is completed)

1. Born before 1957 ☐ Yes ☐ No
2. Dose 1 — Given on or after first birthday ___/___/___
3. Dose 2 — Given at least 30 days after Dose 1 and after 15 months of age ___/___/___

B. Measles (rubeola)

1. Had disease. Confirmed by physician record. ___/___/___
2. Titer report must be attached _____ Immune _____ Non-immune ___/___/___
3. Dose 1 — Immunized with live measles vaccine on or after first birthday ___/___/___
   Dose 2 — Immunized with live measles vaccine 30 days after Dose 1 ___/___/___

C. Mumps

1. Had disease. Confirmed by physician record. ___/___/___
2. Titer report must be attached _____ Immune _____ Non-immune ___/___/___
3. Immunized with mumps vaccine on or after first birthday ___/___/___

D. Rubella

1. Had disease. Titer report must be attached _____ Immune _____ Non-immune ___/___/___
2. Immunized with rubella vaccine on or after first birthday ___/___/___

E. Tetanus-Diphtheria (primary series with DtaP or DTP and booster with Td in the last 10 years)

1. Primary series with DtaP or DTP 1.___/___/___ 2. ___/___/___ 3. ___/___/___ 4. ___/___/___
2. Tetanus-diphtheria booster (Td) ___/___/___

F. Polio

Completed primary series of polio immunization: ☐ Yes ☐ No

Type of vaccine: ☐ Oral (3 doses required) ☐ Inactivated (4 doses required) ☐ Completed ___/___/___

G. Tuberculosis screening (PPD required regardless of prior BCG inoculation)

1. Does the student have signs or symptoms of active TB? ☐ Yes ☐ No If yes, proceed with additional evaluation to exclude active TB disease including tuberculin testing, chest X-ray, and sputum evaluation as indicated.
2. Is the student a member of a high-risk group? ☐ Yes ☐ No If no, STOP. No further evaluation needed at this time. If yes, please complete the following:

☐ PPD (Mantoux) within the past 12 months (tine or monovac not acceptable) ___/___/___

☐ Negative ______ mm induration (horizontal diameter)

☐ Positive (chest X-ray required with positive PPD) Chest X-ray result: ☐ Normal ☐ Abnormal ___/___/___

INH Prophylaxis: ☐ Initiated (attach report) ☐ Completed ___/___/___

☐ Other (please specify):______________________________

H. Hepatitis B (3 doses of vaccine meet the requirement) Dose 1 ___/___/___ Dose 2 ___/___/___ Dose 3 ___/___/___

I. Varicella

1. History of disease ☐ Yes ☐ No
2. Varicella antibody ________ ☐ Reactive ☐ Nonreactive
3. Dose 1 ___/___/___ Dose 2 ___/___/___ (at least one month apart after age of 13)

Part II Recommended Vaccinations

A. Meningococcal (one dose, preferably at entry to College, recommended for first-year students living in residence halls who wish to reduce their risk of meningococcal disease) Quadrivalent polysaccharide vaccine ___/___/___

______Menomune ______Menactra

Provider name ______________________ Signature ______________________

Address ______________________ Date ______________________

Telephone ______________________ Fax ______________________

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Telephone: 845-758-7433 **Fax:** 845-758-7437 **E-mail:** healthservice@bard.edu **Website:** www.bard.edu

Bard Meningococcal Meningitis Vaccination Response

Dear Student/Parent or Guardian:

As the Health Service director at Bard College, I am writing to inform you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis, and the New York State law. New York Public Health Law 2167 requires institutions, including colleges and universities, to distribute information about meningococcal disease and vaccination to all students meeting the enrollment criteria, whether they live on or off campus. This law became effective on August 15, 2003.

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

- A Meningococcal Meningitis Vaccination Response Form signed by the student or student's parent or guardian. The response form must include information on the availability and cost of the meningococcal meningitis vaccine (Menomune™ or Menactra™); AND EITHER
- A record of meningococcal meningitis immunization within the past 10 years; OR
- An acknowledgment of meningococcal disease risks and refusal of meningococcal meningitis immunization signed by the student or student's parent or guardian.

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

Cases of meningitis among teens and young adults 15 to 24 years of age (the age of most college students) have more than doubled since 1991. The disease strikes about 3,000 Americans each year and claims about 300 lives. Between 100 and 125 meningitis cases occur on college campuses each year; of those diagnosed, as many as 15 will die from the disease.

A vaccine is available that protects against four types of the bacteria that can cause meningitis in the United States—types A, C, Y, and W-135. These types account for nearly two-thirds of the meningitis cases among college students. The vaccination is covered by the Bard insurance plan.

We strongly recommend that all students receive the meningitis vaccine prior to arrival at the College.

Please complete the Meningococcal Meningitis Vaccination Response Form below and return it to:
Bard College Student Health Service
PO Box 5000
Annandale-on-Hudson, NY 12504

If you have questions, feel free to contact us at 845-758-7433 or healthservice@bard.edu.
To learn more about meningitis and the vaccine, please feel free to contact our health service and/or consult with your physician. You can also find information about the disease at the following websites: www.health.state.ny.us, www.cdc.gov/meningococcal/about/index.html, and www.acha.org.

Sincerely,
Barbara Jean Briskey, FNP
Director, Bard College Student Health Service

(continued)

Meningococcal Meningitis Vaccination Response Form

New York State public 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:

Bard College Student Health Service
PO Box 5000
Annandale-on-Hudson, NY 12504-5000

To be completed and signed by student or parent/guardian for student under the age of 18.

Student's name ______________________ Date of birth ______________ Date ______________

Check one (1) statement only:

_____ I have received meningococcal meningitis immunization (Menomune™ received within the previous five years or Menactra™ received within the last 10 years).

Immunization Date: ___________________

_____ I have read the information regarding meningococcal meningitis disease. I will obtain immunization against meningococcal meningitis from my private health care provider within 30 days of the date of this form. I agree to submit certification of the date of immunization to the Bard College Health Service.

Please check all that apply:

_____ I have read the information provided on meningococcal meningitis.
_____ I understand the risks of not receiving the meningococcal meningitis vaccination, but decline.
_____ I would like to receive the vaccination and will get it from my health care provider.

Signature ______________________________ Date ______________

Student's home address ______________________________
Street

____
City State Zip Country

Telephone ______________________________ E-mail ______________
Home Cell

All inquiries may be directed to the Bard College Student Health Service, 845-758-7433 or healthservice@bard.edu.

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Bard Student Health and Counseling Services Authorization

Please read and sign both sections.

The health plan provided through Bard College offers benefits including coverage for mental health. Parents or students are allowed to waive the College's health insurance coverage by providing proof of other insurance. Some plans do not cover out-of-area treatment, so we urge parents/students to carefully evaluate their coverage and confirm its portability to the Bard College area. Students eligible for Medicaid should obtain the coverage before they come to Bard.

The Bard Student Counseling Service provides brief, problem-focused treatment, crisis intervention, and referrals. The staff may make off-campus referrals for any student who cannot be accommodated during the course of the semester. Students currently taking medication for an emotional condition and/or learning differences (including attention deficit disorder) should make arrangements to have the medication monitored by the prescribing physician/psychiatrist at home or to transfer to an off-campus physician/psychiatrist in the Bard area. Students who have been in psychotherapy and anticipate the need or desire to continue psychotherapy while at Bard should make arrangements with a local therapist. A student who is seeing an off-campus therapist is responsible for all arrangements, including appointments, transportation, and fees. The health plan provided through the College does cover off-campus counseling with limitations on fee payment and number of visits per academic year. We strongly recommend that plans be made before arrival at Bard so that arrangements about fees, transportation, and the like do not unduly disrupt the student's routine.

By my signature below, I: 1) give the providers at the Student Health Service (SHS) my consent to diagnose and treat medical problems within their scope of practice; 2) acknowledge that I need to establish a relationship with local specialists to treat any ongoing/chronic and/or complicated medical diagnoses; and 3) give SHS permission to share relevant information regarding serious medical issues with the deans of the College, parents/guardians, and other relevant providers as deemed necessary by SHS to provide comprehensive care while I am a student at Bard.

Student must sign _______________________________ Date __________

Students under 18 years of age must have a parent or guardian sign below

Parent/Guardian signature ____________________ Relationship ____________ Date __________

Please submit a photocopy of the front and back of your comprehensive insurance card.

Authorization for Medical Treatment of Minors (student under 18 years of age)

Student name _______________________________

Date of birth ____________________ Social Security number ____________________

Home address _______________________________

Telephone _______________________________

home cell work

I understand that my child may need to quickly procure emergency medical treatment and it may not be possible for the Bard College Student Health Service staff or Bard College representative to notify me before emergency care is rendered. I further understand that the Bard Student Health Service staff (or Bard College representative) will make its best effort to notify me at once in the event of a serious accident or illness involving my child that comes to its attention.

I understand that there are certain risks inherent in any medical treatment—emergency, urgent, and routine care—including the risk that such treatment may not accomplish the desired objective.

I hereby authorize the Bard Student Health Service medical staff at Bard College or representative of Bard College, or any physician, health care institution, or other health care providers that the Bard Student Health Service medical staff or representative of Bard College deems it appropriate to consult with, to provide my child or legal ward emergency care, routine care, and urgent care, including, without limitation, general medical care, psychiatric care, surgery, anesthesia, radiology, medicines, immunizations, or hospitalization.

I have read and understand the above information.

Parent/Guardian signature ____________________ Relationship ____________ Date __________

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