



# HEALTH REPORT

Please read, respond, and return this Health Report to:

**Health Office**  
**Cayuga Community College**  
**197 Franklin Street**  
**Auburn, NY 13021**

**New York State Public Health Law 2167 requires colleges to distribute information about meningococcal disease and vaccinations to ALL students taking 6 credit hours or more (on campus). A signed reply is then required from the student. This report includes the reply section for your signature.**

**New York State Public Health Law 2165 requires proof of immunity to measles, mumps and rubella. This law is mandatory for ALL college students born in 1957 or later and registered for six (6) credit hours or more (on campus).**

Students who will work in the campus **Preschool Center** as part of their curriculum must have a physician complete Part V—Preschool Center Students Only section of this report.

**Nursing students** are required to have an annual physical examination (use last page of this report) and must complete Part IV—Nursing Students Only section in this report.

Members of College **athletic teams** are also required to have an annual physical examination (use last page of this report).

*Information recorded on this form is confidential and will not be shared outside of this institution without your consent.*

Student's Name \_\_\_\_\_

Banner ID Number \_\_\_\_\_

# Cayuga Community College

197 Franklin Street • Auburn NY 13021

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name \_\_\_\_\_  
Last First Middle

Home Address \_\_\_\_\_  
Number and Street  
City State Zip

Phone (with area code) ( ) \_\_\_\_\_

Address while attending Cayuga (if same as above, write "SAME"): \_\_\_\_\_

Number and Street \_\_\_\_\_

Phone (with area code) ( ) \_\_\_\_\_

Person to notify in case of emergency \_\_\_\_\_

Address \_\_\_\_\_  
Number and Street  
City State Zip

Phone (with area code) ( ) \_\_\_\_\_

## HEALTH HISTORY

Place an "X" in the appropriate box(es):

- |                                             |                                               |                                                |                                                        |
|---------------------------------------------|-----------------------------------------------|------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Depression           | <input type="checkbox"/> Headaches (recurrent) | <input type="checkbox"/> Scarlet Fever                 |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Diarrhea (recurrent) | <input type="checkbox"/> Heart Defect          | <input type="checkbox"/> Sinusitis                     |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Sore Throat (frequent)        |
| <input type="checkbox"/> Back Problems      | <input type="checkbox"/> Digestive Problems   | <input type="checkbox"/> Jaundice              | <input type="checkbox"/> Tuberculosis                  |
| <input type="checkbox"/> Blood Disorder     | <input type="checkbox"/> Dizziness/Fainting   | <input type="checkbox"/> Joint Disease/Injury  | <input type="checkbox"/> Ulcerative Colitis            |
| <input type="checkbox"/> Chicken Pox        | <input type="checkbox"/> Ear Trouble          | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> <b>OTHER</b> (specify): _____ |
| <input type="checkbox"/> Colds (frequent)   | <input type="checkbox"/> Eye Trouble          | <input type="checkbox"/> Pneumonia             | _____                                                  |
| <input type="checkbox"/> Convulsion/Seizure | <input type="checkbox"/> Hay Fever            | <input type="checkbox"/> Rheumatic Fever       | _____                                                  |

\* Disclosure of personal information is voluntary and does not affect your acceptance at Cayuga

Please list any allergies to food, drugs, etc. \_\_\_\_\_

Do you take any medications regularly?  Yes  No If "Yes," please list drug(s) and dosage(s) \_\_\_\_\_

Please list any serious injuries, illness, fractures, dislocations or surgeries: \_\_\_\_\_

Do you have any disability or impairment of which we should be aware? \_\_\_\_\_

Are you currently receiving treatment at a clinic or by a physician (other than regular check-ups)?

Yes  No If "Yes," please explain: \_\_\_\_\_

## IMMUNIZATION RECORD

### Part I: **REQUIRED A or B** by NYS PHL 2165

#### A. M.M.R. (Measles, Mumps, Rubella—two doses required.)

1. Dose 1 given at age 12-15 months or later. \_\_\_\_\_
2. Dose 2 given at age 4-6 years or later, and at least one month after first dose. \_\_\_\_\_

#### B. Measles (Rubeola)

1. **Two dates** of measles immunization. **Both** doses must be given after 1967 **and** no more than 4 days before your first birthday.

First Date \_\_\_\_\_ Second Date \_\_\_\_\_

**or** 2. Date of Measles (Rubeola) Titer \_\_\_\_\_ Results  Positive  Negative

#### Rubella (German Measles)

1. Date of **at least one** rubella immunization. **Must** be no more than 4 days before your first birthday.

First Date \_\_\_\_\_ Second Date \_\_\_\_\_

**or** 2. Date of Rubella Titer \_\_\_\_\_ Results  Positive  Negative

#### Mumps

1. Date of **at least one** mumps immunization. **Must** be no more than 4 days before your first birthday.

First Date: \_\_\_\_\_ Second Date \_\_\_\_\_

**or** 2. Date of Mumps Titer \_\_\_\_\_ Results  Positive  Negative

### Part II: **REQUIRED A or B** by NYS PHL 2167

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

#### Meningococcal Meningitis vaccine

*Check one box only.*

- A.  Menomune™ Meningococcal polysaccharide vaccine Date \_\_\_\_\_  
 Menactra™ Meningococcal conjugate vaccine Date \_\_\_\_\_

- B.  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 have decided that I (my child) will **not** obtain immunization against meningococcal meningitis disease at this time.

Signature of Student (Parent/Guardian for student under age 18) \_\_\_\_\_ Date \_\_\_\_\_

### Part III: **RECOMMENDED VACCINES AND TESTING**

Tetanus (Td) Booster Date \_\_\_\_\_ (should be given every 10 years)

Tuberculin Skin Test (PPD) Test Date \_\_\_\_\_ Results  Positive  Negative

Hepatitis B Vaccine: Date 1 \_\_\_\_\_ Date 2 \_\_\_\_\_ Date 3 \_\_\_\_\_

### Part IV: **NURSING STUDENTS ONLY**

1. Rubella Antibody Titer Date \_\_\_\_\_ Results \_\_\_\_\_
2. Rubeola Antibody Titer Date \_\_\_\_\_ Results \_\_\_\_\_
3. Tuberculin Skin Test (PPD) every 12 months Date \_\_\_\_\_ Results \_\_\_\_\_  
If positive, chest X-ray Date \_\_\_\_\_ Results \_\_\_\_\_  
Any treatment for the positive skin test?  Yes  No Drug: \_\_\_\_\_ Started \_\_\_\_\_ Completed \_\_\_\_\_
4. Tetanus/Diphtheria (needed within 10 years) Date \_\_\_\_\_
5. Chicken Pox/Shingles Disease  Yes  No  
Blood Test (Varicella) needed if no disease history Date \_\_\_\_\_ Results \_\_\_\_\_
6. Hepatitis B Vaccine Date 1 \_\_\_\_\_ Date 2 \_\_\_\_\_ Date 3 \_\_\_\_\_  
Vaccine Declined: \_\_\_\_\_

### Part V: **PRESCHOOL CENTER STUDENTS ONLY**

1. Is this person free of communicable diseases?  Yes  No
2. Is this person physically fit to take part in this program?  Yes  No
3. Has this person had a tuberculin skin test (PPD) during the past year?  Yes  No  
If "yes," please indicate Date \_\_\_\_\_ Results \_\_\_\_\_

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Date

