THE COLLEGE OF NEW ROCHELLE

SCHOOL OF NURSING
HEALTH ASSESSMENT FORM

- ☐ BSN
- ☐ Individualized Track
- ☐ Second Degree
- ☐ RN (NSG V/VI Only)
- ☐ Graduate
- ☐ Nurse Practitioner

PART I *To be completed by applicant*

Semester: _____ SSN#: ☐☐☐☐☐☐☐☐☐

Name: _____ Age: ☐☐ Birth Date: M M D D Y Y Y Y

(First) *(M.I.)* *(Last)*

Home Address: _____

(Number and Street) *(City)* *(State)* *(Zip)*

Email Address: _____

Cell Phone (Self): _____ Business Phone (Self): _____

Parent or Guardian or Spouse: _____ Home Phone: _____

Business Phone (Father): _____ Business Phone (Mother): _____

Health Insurance Company and Policy #: _____

or Medicaid #: _____

(Please provide a copy of the insurance card, front and back)

HEALTH HISTORY *(Complete in its entirety)*

Allergies to medications, food, and other substances. *(Include specific reaction.)*

If none, so state: _____

Place one check (✔) in the appropriate column that corresponds to each item below. If "yes," provide details and dates:

	Yes	No		Yes	No		Yes	No
Convulsive Disorder			Skin Rashes			Chicken Pox……/……/……		
Diabetes			High Blood Pressure			Frequent Diarrhea		
Emotional Problems			Kidney Disease			Shortness of Breath		
Headaches			Anemia			Recent Weight Loss/Gain		
Asthma			Tuberculosis			Smoke Cigarettes		
Problems with Alcohol			Eating Disorder			Night Sweats		
Depression			Hepatitis			Heart Disease		

Details and dates: _____

Provide history of any medical conditions and/or surgical procedures: _____

State medications taken routinely, including medication taken on a daily basis. If none, so state: _____

☐ I affirm the health history and above information are complete and accurate. Also, I give the Office of Counseling and Health Services permission to release my Health Status Report Form to the School of Nursing for the purpose of clinical placement.

Student Signature: _____ Date: M M D D Y Y Y Y

PLEASE SUBMIT THIS FORM TO: THE OFFICE OF COUNSELING AND HEALTH SERVICES, ANGELA HALL

29 Castle Place, New Rochelle, NY 10805 • Tel: 914-654-5311 • Fax: 914-654-5885 • www.cnr.edu

112014

PART II—AUTHORIZATION FOR EMERGENCY TREATMENT

The undersigned represents that (student's name) _____ does not suffer any physical or mental condition requiring any special consideration, therapy or treatment which has not been made known in a letter addressed to The College of New Rochelle Office of Counseling and Health Services.

It is understood that while the College makes an effort to secure quality emergency medical care for the student, the College, its trustees, officers, employees or agents are not responsible for any harm to the student which results from the negligence of third parties in providing such care.

It is understood that the College will attempt to communicate immediately with the student's parent or guardian to inform them of emergency measures. However, such communication is not pre-condition to the permission and authorization hereby above extended to the authorities of The College of New Rochelle.

Date: M M D D Y Y Y Y

Signature: _____ OR Signature: _____
(Parent or Guardian) *(Student 18 years or older)*

IMMUNIZATION RECORD

PART III—STRONGLY RECOMMENDED *(All information must be in English)*

To be completed and signed by a health care provider *(Dates must include Month, Day, Year)*

VARICELLA VACCINE *(Please check (✔) only one below)*

☐ 1. Had disease; confirmed by office record M M D D Y Y Y Y

☐ 2. Immunized with vaccine. Two doses required.

Dose # 1 Date Immunized: M M D D Y Y Y Y

Dose # 2 Date Immunized: M M D D Y Y Y Y *(30 days after first dose)*

HEPATITIS A *(Please check (✔) only one below)*

☐ 1. Immunization (Hepatitis A)

Dose # 1 M M D D Y Y Y Y Dose # 2 M M D D Y Y Y Y

☐ 2. Immunization (Combined Hepatitis A and B Vaccine)

Dose #1 M M D D Y Y Y Y Dose #2 M M D D Y Y Y Y Dose #3 M M D D Y Y Y Y

SEASONAL FLU VACCINE *(Please check (✔) only one below)*

☐ Intranasal ☐ IM M M D D Y Y Y Y

PART IV—REQUIRED *(All information must be in English)*

MENINGITIS This notice is required by Public Health Law § 2167

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

MENINGOCOCCAL (One dose within 10 years recommended by NYS PHL § 2167)

Please complete by checking (✔) only one box and signing.

☐ Had the meningococcal (Menomune™) vaccine within the past 10 years (Revaccinate every 3–5 years if increased risk continues.) M M Y Y Y Y

☐ Had the meningococcal (Menactra™) vaccine M M Y Y Y Y

☐ 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.

Signature: _____ Date: M M D D Y Y Y Y
(Student or Parent/Guardian)

*The College of New Rochelle Office of Counseling and Health Services provides all required titers and vaccines at student discount prices.

TETANUS, DIPHTHERIA, PERTUSSIS (Tdap)

1. Completed primary series of four doses with DTaP, DTP, DT or TD M M D D Y Y Y Y

(Please check (✔) only one below)

☐ 2. Booster: Tdap *(preferred)* to replace a single dose of Td for booster immunization at least 2–5 years since last dose of Td, depending on age of patient M M D D Y Y Y Y

☐ 3. Booster: Td within the last ten years M M D D Y Y Y Y

POLIO

1. Completed primary series of polio immunizations ☐ Yes ☐ No

Dose #1 M M D D Y Y Y Y Dose #2 M M D D Y Y Y Y

Dose #3 M M D D Y Y Y Y Dose #4 M M D D Y Y Y Y

MMR (MEASLES, MUMPS, RUBELLA) *(If given instead of individual immunizations)*

1. Dose #1 — Immunized on or after first birthday M M D D Y Y Y Y

2. Dose #2 — Immunized 28 days after 1st dose M M D D Y Y Y Y

MEASLES (RUBEOLA) *(Please check (✔) only one below)*

☐ 1. Had disease; confirmed by office record M M D D Y Y Y Y

☐ 2. Immunized with measles vaccine. Two doses required.

Dose #1 — Immunized on or after first birthday M M D D Y Y Y Y

Dose #2 — Immunized 28 days after 1st dose M M D D Y Y Y Y

☐ 3. Has report of immune titer.* Specify date of titer. M M D D Y Y Y Y

MUMPS *(Please check (✔) only one below)*

☐ 1. Had disease; confirmed by office record M M D D Y Y Y Y

☐ 2. Immunized with vaccine on or after first birthday M M D D Y Y Y Y

☐ 3. Has report of immune titer.* Specify date of titer. M M D D Y Y Y Y

GERMAN MEASLES (RUBELLA) *(Please check (✔) only one below)*

☐ 1. Immunized with vaccine on or after first birthday M M D D Y Y Y Y

☐ 2. Has report of immune titer.* Specify date of titer. M M D D Y Y Y Y

Note: Physician diagnosis of Rubella is not acceptable proof of immunity.

HEPATITIS B VACCINE — MUST RECEIVE ALL THREE DOSES

1. Dose #1 M M D D Y Y Y Y

2. Dose #2 — Immunized 30 days after the 1st dose M M D D Y Y Y Y

3. Dose #3 — Immunized 6–12 months after the 2nd dose M M D D Y Y Y Y

AND

4. Has report of immune titer (Hepatitis B Surface Antibody) M M D D Y Y Y Y ☐ Immune ☐ Non Immune

Go to #5 only if non-immune

5. Dose #1 M M D D Y Y Y Y Dose #2 M M D D Y Y Y Y Dose #3 M M D D Y Y Y Y

6. Has report of immune titer.* Specify date of titer. M M D D Y Y Y Y ☐ Immune ☐ Non Immune

*The College of New Rochelle Office of Counseling and Health Services provides all required titers and vaccines at student discount prices.

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PART IV—IMMUNIZATION RECORD CONTINUED… *To be completed and signed by a health care provider*

Varicella Zoster Titer
Date: M M D D Y Y Y Y Count: _____ ☐ Immune ☐ Non Immune

Rubella (German Measles) Titer
Date: M M D D Y Y Y Y Count: _____ ☐ Immune ☐ Non Immune Re-Vaccination M M D D Y Y Y Y

Rubeola (Measles) Titer
Date: M M D D Y Y Y Y Count: _____ ☐ Immune ☐ Non Immune Re-Vaccination M M D D Y Y Y Y

Mumps Titer
Date: M M D D Y Y Y Y Count: _____ ☐ Immune ☐ Non Immune Re-Vaccination M M D D Y Y Y Y

PART V—PHYSICAL EXAM (ANNUAL REQUIREMENT)

CBC *(within the past 12 months)* M M D D Y Y Y Y Result: _____

URINALYSIS *(within the past 12 months)* M M D D Y Y Y Y Result: _____

TUBERCULOSIS SKIN TESTING (TST)— *(Please check (✔) one only.* SEE ATTACHMENT FIRST.)

1. TST *(Give date and test results.)*
M M D D Y Y Y Y Result: ☐ Positive ☐ Negative

2. Positive TST—Chest x-ray required. *(Give date and result of chest x-ray.)*
M M D D Y Y Y Y Result: ☐ Positive ☐ Negative

With (+) TST was patient treated? If so: when, how long, and with what? _____
With (+) TST—A repeat chest x-ray is required if symptoms of persistent cough, weight loss, and night sweats have been present for the last three months.
M M D D Y Y Y Y Result: ☐ Positive ☐ Negative

3. Had BCG vaccine—Chest x-ray required if TST not done or if TST positive.
M M D D Y Y Y Y Result: ☐ Positive ☐ Negative

PHYSICAL EXAM

Height	Weight		Mouth & Throat			Abdomen	
Head			Neck			GYN	
Eyes			Chest			Lymphatics	
Vision	Corrected		Pulse	BP	R	Extremities	
Ears			Heart			Neurological	
Nose			Breasts			Skin	

Based on physical examination and medical history, the health care provider finds the above student free from health impairments which can carry potential risks to patients and personnel, and might interfere with required duties.

Respiratory protection: Applicant is medically cleared to wear respiratory protection: ☐ Yes ☐ No

Health Care Provider: _____
(Print) *(Signature)*

Address: _____

License #: _____ Phone #: _____ Date: M M D D Y Y Y Y
(Required)

VACCINE INFORMATION STATEMENT

Meningococcal Vaccines

What You Need to Know

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 What is meningococcal disease?

Meningococcal disease is a serious bacterial illness. It is a leading cause of bacterial meningitis in children 2 through 18 years old in the United States. Meningitis is an infection of the covering of the brain and the spinal cord.

Meningococcal disease also causes blood infections.

About 1,000–1,200 people get meningococcal disease each year in the U.S. Even when they are treated with antibiotics, 10–15% of these people die. Of those who live, another 11%–19% lose their arms or legs, have problems with their nervous systems, become deaf, or suffer seizures or strokes.

Anyone can get meningococcal disease. But it is most common in infants less than one year of age and people 16–21 years. Children with certain medical conditions, such as lack of a spleen, have an increased risk of getting meningococcal disease. College freshmen living in dorms are also at increased risk.

Meningococcal infections can be treated with drugs such as penicillin. Still, many people who get the disease die from it, and many others are affected for life. This is why preventing the disease through use of meningococcal vaccine is important for people at highest risk.

2 Meningococcal vaccine

There are two kinds of meningococcal vaccine in the U.S.:

- Meningococcal conjugate vaccine (**MCV4**) is the preferred vaccine for people 55 years of age and younger.
- Meningococcal polysaccharide vaccine (**MPSV4**) has been available since the 1970s. It is the only meningococcal vaccine licensed for people older than 55.

Both vaccines can prevent 4 types of meningococcal disease, including 2 of the 3 types most common in the United States and a type that causes epidemics in Africa. There are other types of meningococcal disease; the vaccines do not protect against these.

3 Who should get meningococcal vaccine and when?

Routine vaccination

Two doses of MCV4 are recommended for adolescents 11 through 18 years of age: the first dose at 11 or 12 years of age, with a booster dose at age 16.

Adolescents in this age group with HIV infection should get three doses: 2 doses 2 months apart at 11 or 12 years, plus a booster at age 16.

If the first dose (or series) is given between 13 and 15 years of age, the booster should be given between 16 and 18. If the first dose (or series) is given after the 16th birthday, a booster is not needed.

Other people at increased risk

- College freshmen living in dormitories.
- Laboratory personnel who are routinely exposed to meningococcal bacteria.
- U.S. military recruits.
- Anyone traveling to, or living in, a part of the world where meningococcal disease is common, such as parts of Africa.
- Anyone who has a damaged spleen, or whose spleen has been removed.
- Anyone who has persistent complement component deficiency (an immune system disorder).
- People who might have been exposed to meningitis during an outbreak.

Children between 9 and 23 months of age, and anyone else with certain medical conditions need 2 doses for adequate protection. Ask your doctor about the number and timing of doses, and the need for booster doses.

MCV4 is the preferred vaccine for people in these groups who are 9 months through 55 years of age. MPSV4 can be used for adults older than 55.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4 Some people should not get meningococcal vaccine or should wait.

- Anyone who has ever had a severe (life-threatening) allergic reaction to a previous dose of MCV4 or MPSV4 vaccine should not get another dose of either vaccine.
- Anyone who has a severe (life threatening) allergy to any vaccine component should not get the vaccine. *Tell your doctor if you have any severe allergies.*
- Anyone who is moderately or severely ill at the time the shot is scheduled should probably wait until they recover. Ask your doctor. People with a mild illness can usually get the vaccine.
- Meningococcal vaccines may be given to pregnant women. MCV4 is a fairly new vaccine and has not been studied in pregnant women as much as MPSV4 has. It should be used only if clearly needed. The manufacturers of MCV4 maintain pregnancy registries for women who are vaccinated while pregnant.

Except for children with sickle cell disease or without a working spleen, meningococcal vaccines may be given at the same time as other vaccines.

5 What are the risks from meningococcal vaccines?

A vaccine, like any medicine, could possibly cause serious problems, such as severe allergic reactions. The risk of meningococcal vaccine causing serious harm, or death, is extremely small.

Brief fainting spells and related symptoms (such as jerking or seizure-like movements) can follow a vaccination. They happen most often with adolescents, and they can result in falls and injuries.

Sitting or lying down for about 15 minutes after getting the shot—especially if you feel faint—can help prevent these injuries.

Mild problems

As many as half the people who get meningococcal vaccines have mild side effects, such as redness or pain where the shot was given.

If these problems occur, they usually last for 1 or 2 days. They are more common after MCV4 than after MPSV4.

A small percentage of people who receive the vaccine develop a mild fever.

Severe problems

Serious allergic reactions, within a few minutes to a few hours of the shot, are very rare.

6 What if there is a serious reaction?

What should I look for?

Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or behavior changes.

Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a severe allergic reaction or other emergency that can't wait, call 9-1-1 or get the person to the nearest hospital. Otherwise, call your doctor.
- Afterward, the reaction should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor might file this report, or you can do it yourself through the VAERS web site at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

VAERS is only for reporting reactions. They do not give medical advice.

7 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling **1-800-338-2382** or visiting the VICP website at **www.hrsa.gov/vaccinecompensation**.

8 How can I learn more?

- Ask your doctor.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's website at **www.cdc.gov/vaccines**

Vaccine Information Statement (Interim)

Meningococcal Vaccine

10/14/2011

42 U.S.C. § 300aa-26

Office Use Only