COLGATE UNIVERSITY STUDENT HEALTH SERVICES
13 Oak Drive, Hamilton, NY 13346 **Phone:** 315-228-7750 **Fax: 315-228-6823**
studenthealth@colgate.edu

COLGATE UNIVERSITY

TO INCOMING STUDENTS: REPORT OF MEDICAL HISTORY (please print)

Last Name ____ First Name ____ Middle Initial ____ Preferred First Name ____ Pronouns ____ Cell Phone # ____

Address ____ City ____ State ____ Country (If not U.S.A.) ____ Zip + 4 ____

Gender at Birth______Gender Identity ________Date of Birth (Month / Day / Year)_____/_____/_____Colgate Class Year__________Colgate Student ID # ____________

Parent 1: Name ____ Home Address ____ Home Phone ____ Cell Phone # ____

Parent 2: Name ____ Home Address ____ Home Phone ____ Cell Phone # ____

FAMILY HISTORY: Adopted: Yes ______No_____

	Age	State of Health	Occupation	Age of Death	Cause of Death
Parent 1					
Parent 2					
Siblings					

Have any of your relatives ever had any of the following

	Yes	No	Relationship
Diabetes			
Kidney Disease			
Heart Disease			
High Blood Pressure			
Blood Clots			
Cancer			
Epilepsy/Other Neuro			

Please explain: ____________

PERSONAL HISTORY: PLEASE ANSWER ALL QUESTIONS. Comment on all positive answers in space below.

Have you had?	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Malaria			Recurrent Headaches			Stomach or Intestinal Trouble			Chronic Cough			ALLERGY TO: Penicillin/Amoxicillin		
Tuberculosis			Head Injury w/unconsciousness						Shortness of Breath					
Mononucleosis						Gallbladder Trouble			Hay Fever			Cephalosporins		
Sinusitis			Fainting Spells			Skin Problem			Asthma			Sulfa		
Eye Trouble			Palpitations (Heart)			Urine Infection			Tumor/Cancer (explain)			Insect Bites		
Ear Infections			High Blood Pressure			Kidney Problem			SURGERY:			Foods (which)		
Throat Infections			Heart Murmur			Disease/Injury of Joints			Appendectomy			Other (explain)		
Insomnia			Rheumatic Fever			Back Problems			Tonsillectomy			**Do you carry an Epipen?**		
Anxiety/Depression			Recent Weight Change			Seizures			Hernia Repair					
Diabetes			Hepatitis			Weakness/Paralysis			Other (explain)			If so for what allergy?		

REMARKS OR ADDITIONAL INFORMATION: ____________

Current Medications and Doses: ____________

Will you Need Colgate to Prescribe your Medications?YES or NO — If Yes, Which Medications: ____________

Medication Allergies: If yes what happens. ____________

	No	Yes (Explain) Attach separate pg. if needed
Has your physical activity been restricted during the past five years?		
Have you received treatment or counseling for mental health issues such as depression, anxiety, bipolar d/o, attention deficit, eating d/o, or other mental health diagnosis. If so, what arrangements have been made for ongoing care?		
Have you been hospitalized other than noted above in Personal History?		
Do you have any concerns about eating or weight?		
Do you currently receive allergy shots?		
Are you being treated for any chronic or long term condition? If so, what arrangements have been made for ongoing care?		

SPECIAL NEEDS

Do you believe that you have any special needs that the University should consider, in order to provide assistance with living and learning conditions?
□ Hearing □ Vision □ Speech □ Dietary □ Allergies □ Learning □ Motor Disabilities □ Mental Health, ADHD or Autism Spectrum Support □ Other
Describe:____________

Evelyn Lester, Director of Academic Support and Disability Services, is available to discuss your concerns. Phone: 315-228-7375 or e-mail elester@colgate.edu

I certify that, to the best of my knowledge, this information is correct. CONSENT FOR TREATMENT: The staff of the Colgate University Student Health Service has my permission for care and treatment; in person or via telehealth (virtual visits). This may additionally include care, treatment, **and exchange of medical information necessary for ongoing care** by any hospital, surgeon, physician, **psychiatrist/psychologist (including telepsychiatry)** or radiologist deemed necessary for appropriate medical, psychiatric, and/or surgical treatment. *If under 18, parent/guardian must sign.*

Sign Here ____________ *Student's Signature* *Date:*

____________ Parent/Guardian Signature if Age < 18 *Date:* Sign Here

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2022-2023 IMMUNIZATION FORM for INCOMING STUDENTS

Incoming students must complete the immunization requirements before arriving on campus.

PLEASE NOTE: IF YOU SUBMIT THIS FORM AS YOUR PROOF OF IMMUNIZATION HISTORY, IT MUST BE SIGNED OR STAMPED BY YOUR MEDICAL PROVIDER.

STUDENT HEALTH SERVICES WILL ACCEPT A SIGNED COPY OF YOUR IMMUNIZATION RECORD INSTEAD OF THIS FORM.

LAST NAME:	FIRST NAME , MIDDLE INITIAL:	PREFERRED FIRST NAME:	DATE OF BIRTH *(MM/DD/YYYY)*:
COLGATE EMAIL ADDRESS:		Anticipated Year of Graduation from Colgate	

REQUIRED

MMR 2 DOSES REQUIRED OR INDIVIDUAL VACCINES AS LISTED BELOW. ADMINISTERED AFTER 1ST BIRTHDAY	DOSE #1		DOSE #2	
OR				
Measles (Rubeola) 2 DOSES REQUIRED. MUST BE ADMINISTERED AFTER 1ST BIRTHDAY	DOSE #1	DOSE #2	OR	LABORATORY EVIDENCE OF IMMUNITY ***UPLOAD LAB REPORT***
Mumps 1 DOSE REQUIRED. MUST BE ADMINISTERED AFTER 1ST BIRTHDAY	DOSE #1	DOSE #2	OR	LABORATORY EVIDENCE OF IMMUNITY ***UPLOAD LAB REPORT***
Rubella (German Measles) 1 DOSE REQUIRED. MUST BE ADMINISTERED AFTER 1ST BIRTHDAY	DOSE #1		OR	LABORATORY EVIDENCE OF IMMUNITY ***UPLOAD LAB REPORT***
Hepatitis B 3 DOSES REQUIRED / DOSE #1	DOSE #2	DOSE #3	OR	LABORATORY EVIDENCE OF IMMUNITY ***UPLOAD LAB REPORT***
Tetanus-Diphtheria-Pertussis DOSES:		**Circle One: Tdap or Td** (WITHIN THE LAST 10 YEARS)		LAST TDAP BOOSTER DATE
Varicella (Chicken Pox) 2 DOSES REQUIRED OR DATE OF ILLNESS / ILLNESS DATE OR	DOSE #1	DOSE #2	OR	*OR* LABORATORY EVIDENCE OF IMMUNITY ***UPLOAD LAB REPORT***
COVID (Completed series and Booster Required) LIST VACCINE NAME:	DOSE #1	DOSE #2 if applicable	DOSE #3/Booster	
Meningococcal ACWY DOSE SINCE AGE 16 AND WITHIN THE PAST 5 YEARS		LAST DOSE:	LIST VACCINE NAME OR SEROGROUPS COVERED:______	

OR

As required by NYS Public Health Law, I have read or had explained to me, the information about meningococcal disease and I decline to receive the vaccine at this time and understand the risks. Student or Parent/Guardian (if student under age 18). Signature____________________ Date__________

RECOMMENDED

THE VACCINES LISTED BELOW ARE RECOMMENDED BASED ON AGE OR DISEASE CRITERIA. PLEASE CHECK WITH YOUR CLINICIAN.

Hepatitis A / DOSE #1	DOSE #2		OR	LABORATORY EVIDENCE OF IMMUNITY ***UPLOAD LAB REPORT***
HPV (Human Papillomavirus) ☐ HPV4 or ☐ HPV9	DOSE #1	DOSE #2	DOSE #3	
Meningococcal B (Bexsero/Trumenba) LIST VACCINE NAME:	DOSE #1	DOSE #2	DOSE #3 if applicable	

ADDITIONAL VACCINES

INFLUENZA VACCINE RECOMMENDED ANNUALLY

Polio	DOSE #1	DOSE #2	DOSE #3	DOSE #4
Other (pneumococcal, typhoid, etc.) LIST VACCINE NAMES AND DATES				

PROVIDER INFORMATION

SIGNING PROVIDER IS VERIFYING ALL DATES ABOVE ARE ACCURATE

Provider Name (Please Print)	**Title**	**Clinical or Organization Stamp**
Address	**Phone**	
Signature	**Date**	

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TUBERCULOSIS (TB) SCREENING for the 2022-2023 ACADEMIC YEAR

Complete sections A and B. If you answer yes to any questions, please have your health care provider complete section C. Form must be signed and returned to above address by July 1, 2022.

Name (please print): ______________________________ Colgate ID#: ____________
Last First MI

Country of Birth: ______________ Year arrived in US: ____________

SECTION A: History of Tuberculosis (TB)?

1. Have you ever been sick with tuberculosis? **YES** NO

2. Have you ever had a positive PPD, TB Quantiferon test, or T-SPOT? **YES** **NO**

AND

SECTION B: At Risk for Tuberculosis (TB)?

1. Were you born in, or have you lived, worked or visited for more than one month a country with High TB Burden: **YES** **NO**
If unsure- review list found at: https://www.vdh.virginia.gov/content/uploads/sites/175/2022/02/High-Burden-TB-Countries-2022.pdf

If yes, what country/countries? ______________ How long? ____________
Reason (please circle) Born there Tourist Work School Other ________

2. Do any of the following conditions or situations apply to you?
   a) Have you ever lived with or been in close contact to a person known or suspected of being sick with TB? **YES** **NO**
   b) Have you ever lived, worked, or volunteered in any homeless shelter, prison/jail, hospital or drug rehabilitation unit, nursing home or residential healthcare facility? **YES** **NO**

Sign Here Student Signature ______________________________ Date ____________

If you answered no to all of the above questions, skip Section C, you are done.
If you answered yes to any of the above questions, your health care provider must complete Section C below.

SECTION C: ATTENTION HEALTH CARE PROVIDER: If patient answered YES to any of the above questions, proof of a PPD, QuantiFERON –TB Gold or T-SPOT is REQUIRED. If PPD results are 10mm or more, or QuantiFERON-TB Gold or T-SPOT are positive, a chest x-ray is REQUIRED. Testing and/or chest x-ray must be done within one calendar year prior to admittance (unless history of positive PPD). If student has history of positive PPD, chest x-ray is required. History of BCG vaccination does not prevent testing of a member of a high risk group.

PPD: Date placed ____________ Date read ____________ # of mm induration ____________

OR

QuantiFERON-TB Gold or T-SPOT: Result Date ____________ Result (attach lab report) ____________

OR

Date of chest x-ray ____________ Result ____________

If positive testing, did student complete a course of oral therapy?If yes, what type and when? **YES** **NO**

____

(months & year) and for how many months did student take oral therapy? ____________ **(# of months)**

PROVIDER INFORMATION REQUIRED

(please print) Name of health care provider ____________ Phone number of practice ____________ Date ____________

Signature of health care provider ____________ Practice Address ____________

Colgate University Student Health Services
140 Broad St. Hamilton NY, 13346 Phone: 315-228-7750 Fax: 315-228-6823 studenthealth@colgate.edu

PATIENT CONSENT FORM

Colgate ID #:________________

Please initial

CONSENT FOR TREATMENT:
I am voluntarily seeking medical care and treatment from Colgate Student Health Services ("SHS") and give permission to the medical staff of SHS to examine me, make diagnoses, and provide treatment to me in accordance with the information, explanations, and recommendations they provide me.

Please initial

CONSENT TO BILL:
SHS does not bill for office visits and does not bill most insurances. SHS can bill the University sponsored insurance for Immunizations and will forward medical records as appropriate for referrals. **If SHS would bill my insurance,** I authorize payment of benefits to Colgate Student Health Services (SHS) or will reimburse SHS if I am paid directly by my carrier. I understand that my insurance may not cover all charges deemed medically necessary by SHS and that I am responsible for any part of the charges that are not covered by my insurance and I will be billed directly for those services.
I hereby authorize that SHS may furnish information concerning my illness and treatment to my insurance carrier(s) in accordance with its privacy policy.
I am advised that any tests (blood work and other specimens) sent to an outside laboratory will result in additional charges that will be billed to my insurance carrier and/or will be billed directly to me by the laboratory.

Please initial

PATIENT RIGHTS AND RESPONSIBILITIES:
I have received a copy of the SHS Patient Rights and Patient Responsibilities

Please initial

PATIENT NOTICE OF CONFIDENTIALITY PRACTICES :
I acknowledge that I have received a copy of the SHS Notice of Confidentiality Practices

Please initial

Medical Portal Activation Information
SHS would like to email the activation information for your medical portal to your Colgate email address. Email is not encrypted and can be intercepted. There is a risk that the required information could be viewed by an unauthorized person when transmitted over the Internet. By signing your initials in this area you agree to receive this information via email. If you would prefer to receive this information by phone mark an "X" in the initial box and call SHS at 315-228-7750 for your log on information.

Please initial -Text

Please initial -Email

Appointment Reminders
By initialing in these boxes you consent to receiving appointment reminders via your Colgate email and/or text message. If you would like to receive text reminders please confirm your prefered mobile number here: ______________________

This signature acknowledges all of the above initialed.

______________________	X______________________	____ ____ ____
Patient Name (please print)	***Patient Signature***	***Date***

If student is < 18 years old at the time of arrival on campus, personal representative (parent, guardian, power of attorney, etc) signature is required, please fill out the information below:

______________________	X______________________	____ ____ ____
Personal Representative Name (please print)	***Signature of Personal Representative***	***Date***

Authority of Personal Representative to Sign for Patient (**check one**): □Parent □Guardian □Power of Attorney □ Other: ____________