Bard Required Medical Forms Checklist and Packet

MUST BE COMPLETED AND RETURNED

The State of New York and Bard College require all students to submit the attached medical forms prior to registration for courses. Below is a checklist of the required documents included in this packet. Please complete and return these documents by the deadline stated on the Accepted Student Forms and Downloads web page at bard.edu/admission/accepted/forms.

- ☐ **Medical History (pages 1, 2, and 3)** These three pages should be completed by the student and/or parent/guardian.

- ☐ **Physical Examination (page 4)** A recent (within the last year) physical exam is required of all students. This page should be completed and signed by your health care provider. A copy of the health care provider's notes from a recent physical may be submitted in lieu of this page.

- ☐ **Immunization Record (page 5)** This page must be completed and signed by your health care provider. A copy of immunization records certified by your health care provider or a school nurse may be submitted in lieu of this page. New York State law requires that these records provide proof of immunity to measles, mumps, and rubella. **Students will not be allowed to register for courses until this document has been submitted.**

- ☐ **Meningitis Response Form (page 6)** This page must be completed and signed by the student and/or parent/guardian, unless the student's official immunization records include a meningococcal meningitis vaccination.

- ☐ **Consent and Authorization for Treatment (page 7)** This page must be completed and signed by the student and/or parent/guardian. This document provides permission for students to be seen and treated at the Student Health Service and Counseling Service.

- ☐ **All forms must be completed and submitted to the address below.** The completed forms may be submitted via fax, mail, or email by the deadline stated on the Accepted Student Forms and Downloads web page at bard.edu/admission/accepted/forms.

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 **Email:** healthservice@bard.edu **Website:** bard.edu/healthservices

Bard Medical History Information (page 1)

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Please note: Each entering student is required to ensure completion of all pages in this packet and return them 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 of birth _____
Last First Middle

_____
Chosen name Gender Preferred pronoun

Telephone _____ Email _____
Home Cell

Home address _____
Street City State Zip Country

Entering as: ☐ First-year ☐ Sophomore ☐ Junior ☐ Senior ☐ Graduate/Program name _____

Emergency Contact:

Name _____ Relationship _____

Telephone _____
Home Work Cell

Email _____

Family History

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

	Age	State of health	Occupation	Age at death	Cause of death
Parent					
Parent					
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 or use an additional page as needed:

(continued)

Medical History Continued (page 2)

Student's name _____ Date of birth _____

Medications

Please list all medications and supplements currently being taken, the dosage, frequency, and condition for which they are being taken.

Medication	Dosage/Frequency	Condition	Prescriber

Use an additional page as needed.

Allergies

Please list all allergies and reactions.

Medications: _____

Foods: _____

Bees/Insects: _____ Do you carry an EpiPen® ☐ Yes ☐ No

Environmental (dust, pollen, grass, trees, animal, etc.): _____

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			Other eating disorder		
Seizure disorder			Hepatitis			Tumor/cancer		
Recurrent headaches/migraines			Kidney disease			Lyme Disease		
Ear/nose/throat problems			Bladder infections			Other chronic illness		
Sinusitis			Back problem			History of surgery		
Eye disease			Bleeding disorder			Overnight hospitalization		
Hearing loss			Clotting disorder			Anxiety/Depression		
Asthma			Anemia			Other psychiatric diagnosis		
Hospitalization w/asthma			Diabetes			Emotional problems		
Recurrent bronchitis			Insulin dependent			If you have a uterus:		
Heart problems			Thyroid disorder			Absent period		
Heart murmur			Mononucleosis			Severe cramps		
High blood pressure			Insomnia					
High cholesterol			Anorexia/bulimia					

*Please list diagnoses, dates, treatment, and current status of all conditions for which you marked "Yes."

(continued)

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Medical History Continued (page 3)

Student's name _____ Date of birth _____

Wellness Assessment

Diet: ☐ No restrictions ☐ Vegetarian ☐ Vegan ☐ Pescatarian ☐ Other _____

Exercise – *type* _____ *frequency* _____

Tobacco use – *type* _____ *for how long?* _____ *how much?* _____

Alcohol use – *type(s)* _____ *amounts* _____ *frequency* _____

Drug use – *type(s)* _____ *amounts* _____ *frequency* _____

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 (page 4)

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Student's name _____ Date of birth _____

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

☐ Male ☐ Female ☐ Transitioning (please describe) _____

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: CBC: Hg/HCT:

Please use an additional sheet of paper, to:

1. describe any significant illnesses, injuries, or hospitalizations in this patient's history,
2. submit a treatment plan for BMI below 18.5,
3. and 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 #

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Bard Immunization Record (page 5)

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Student's name _____ Date of birth _____

Required Immunizations

MMR (measles, mumps, rubella) New York State Public Health Law 2165 requires postsecondary students to show immunity to measles, mumps, and rubella before registering for classes. Persons born prior to January 1, 1957, or taking less than six credits in a semester are exempt from this requirement.

The first dose of vaccine(s) must be given on or after your first birthday, and the second dose at least 28 days after the first.

OPTION 1 – TWO DOSES OF MMR VACCINE

month/day/year

MMR #1 ____/____/____

MMR #2 ____/____/____

OPTION 2 – TWO DOSES OF MEASLES VACCINE

month/day/year month/day/year

Measles #1 ____/____/____ Measles #2 ____/____/____

AND one dose of MUMPS vaccine ____/____/____

AND one dose of RUBELLA vaccine ____/____/____

OPTION 3 – ONE DOSE OF MEASLES VACCINE

month/day/year

Measles #1 ____/____/____ **AND**

One MMR ____/____/____

OPTION 4 – ANTIBODY TITERS (lab reports must be attached)

month/day/year

Measles titer IMMUNE ____/____/____

Mumps titer IMMUNE ____/____/____

Rubella titer IMMUNE ____/____/____

Recommended

MENINGITIS VACCINE – This vaccine is strongly recommended for students living in campus housing

If there are no records of this vaccination, the student/parent must complete the Meningitis Response form on the next page.

Meningitis vaccine #1 ____/____/____

Meningitis vaccine #2 ____/____/____ (if student received vaccine #1 prior to the age of 16)

TUBERCULOSIS SCREENING – PPD recommended 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," further evaluation is not needed at this time; if "yes," please complete the following:

___PPD (Mantoux) within the past 12 months (tine and Monovac are not acceptable) ____/____/____

___ Negative _____mm induration (horizontal diameter)

___ Positive (chest X-ray required with positive PPD)

Chest X-ray result ___ Normal ___ Abnormal Date ____/____/____

INH Prophylaxis ___ Initiated (attach report) ___ Completed ____/____/____

___ Other (please specify) _____

___ Other (please specify) _____

TETANUS-DIPHTHERIA-PERTUSSIS – Most recent vaccine/booster TD ____/____/____ TDap ____/____/____

POLIO – Series completed on IPV/OPV ____/____/____

HEPATITIS B – Three doses HEP B #1 ____/____/____ HEP B #2 ____/____/____ HEP B #3 ____/____/____

HPV – Three doses ___ Gardasil HPV #1 ____/____/____ HPV #2 ____/____/____ HPV #3 ____/____/____

VARICELLA (chickenpox) – Two doses VZV #1 ____/____/____ VZV #2 ____/____/____

Health care provider signature required OR attach an official copy of immunization records (signed by medical provider or school nurse).

Name _____ Address _____

Signature _____ Date _____

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Bard Meningitis Response (page 6)

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Student's name _____ Date of birth _____

*Required Meningococcal Meningitis Response

Meningococcal meningitis: For all students regardless of age, New York State Public Health Law 2167 mandates that you read and sign this form.

Meningitis disease is a severe bacterial infection of the bloodstream or meninges (a thin layer covering the brain and spinal cord). It is a relatively rare disease and usually occurs as a single isolated event. Clusters of cases or outbreaks are rare in the United States. It is transmitted through air via droplets of respiratory secretions and direct contact with an infected person. Direct contact, for these purposes, is defined as oral contact with shared items such as cigarettes or drinking glasses or through intimate contact such as kissing. Exposure to passive and active smoking, bar patronage, and excessive alcohol consumption may put students at increased risk for the disease. Individuals with respiratory infections or compromised immunity, those in close contact with a known case, and travelers to endemic areas of the world are also at increased risk. The early symptoms usually associated with meningococcal disease include fever, severe headache, stiff neck, rash, nausea, vomiting, and lethargy, and may resemble the flu. The disease progresses rapidly, often in as little as 12 hours. The disease is occasionally fatal. The symptoms may appear two to 10 days after exposure, but usually within five days. Casual contact that occurs in a classroom, office, or other public space is not usually significant enough to cause concern. A vaccine is available that protects against some strains of meningitis. For the most part, the vaccine has been shown to be safe, and adverse reactions are mild and infrequent, consisting primarily of redness and pain at the site of injection lasting up to two days. If you wish to receive the meningococcal vaccine, contact your health care provider.

Check one (1) box only and sign. *Student must sign if 18 years of age or older. Parent/guardian must sign for all students under 18.*

☐ I (my child) had the meningococcal meningitis immunization

☐ I have read the information regarding meningococcal meningitis disease and I understand the risk of not receiving the vaccine. I (my child) will not obtain immunization against meningococcal meningitis disease at this time.

Student signature _____ Date _____

Parent signature _____ Date _____

**This form is not required if the student's official vaccination record lists a meningococcal meningitis vaccination.*

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Bard Consent and Authorization for Treatment (page 7)

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Student's name _____ Date of birth _____

Please read and sign both sections as necessary.

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

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's name _____ Date of birth _____

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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