SKIDMORE
COLLEGE

Spring 2024

Dear Skidmore College Summer Program Participants and Parents,

This memo is to clarify available services and to stress the importance and timeliness of completing the enclosed Health Form.

It is requested that the enclosed Health Form be completely and accurately filled out and submitted to your Program Director by June 1, 2024. If you have not filled out and returned these forms completely, you will not be able to participate in this program.

Immunization information is requested for the public health and safety of the campus and the participants. Without documentation of immunity, participants may be asked to leave campus in the event of an outbreak. (**NOTE:** As of 2/15/24, New York State Dept of Health issued a health advisory reporting measles cases in NY, New Jersey and Pennsylvania as well as other states in the country).

New York State law requires meningococcal meningitis vaccination or documentation of refusal of the vaccine, for all summer program participants. Please review the enclosed information carefully, answer all questions on the forms, and obtain all required vaccinations.

If your student is under the age of 18 while participating in a Skidmore College-sponsored program, it is our policy to secure your consent for first aid, triage, and emergency care. Whenever possible, the program will obtain specific permission from you, before referral. Therefore, parents of participants under 18 should be sure to include all possible telephone/cell numbers on the Health Form and complete the authorization at the bottom of page one.

For illness/injury that involves care beyond basic first aid, participants will be referred to nearby community resources, either Urgent Care or the Emergency Department. There are several urgent care clinics less than two miles from campus and the Saratoga Hospital Emergency Department is 1.3 miles away. Campus Safety can assist with transportation to medical care in non-emergency situations. For any type of emergency care needs, we will call an ambulance for transport.

While we are able to accompany program participants for urgent and emergency care needs, we do not have staffing to bring participants to routine medical care appointments. If your student has ongoing medical concerns that require medication, regular treatment and/or support (e.g. physical therapy, psychotherapy or medication management) please make sure you discuss their participation in this program, and time away from home, with their current provider, so that you can develop a plan ahead of time for ongoing support during the program.

Participants of Skidmore College Summer Programs may self-carry/self-administer medications only with a parent and provider written consent. Please thoroughly review the health form, be sure all medications and dosages are written, and sign where appropriate.

International participants attending Skidmore Summer Programs: Please carefully review the immunization and tuberculin screening requirements with your healthcare provider. The requirements may differ from the country in which you reside. The requirements are very specific and **no exceptions** can be made.

Again, we are pleased that you will be here this summer and wish you a safe, happy, and healthy learning experience.

SKIDMORE COLLEGE

2024 Summer Programs Health Form (Page 1)

815 North Broadway
Saratoga Springs, NY 12866-1632
Phone: (518) 580-5590
Fax: (518) 580-5548

PROGRAM INFORMATION

Name of Summer Program:_____

PARTICIPANT INFORMATION

Participant Name: (Last, First)	Preferred Name:	DOB: (MM/DD/YYYY)

Home Address:

Street City State Zip Country

Participant cell phone #:

PARENT/GUARDIAN INFORMATION

Parent/Guardian #1 Name:	**Parent/Guardian #2 Name:**
Address:	Address:
Cell Phone:	Cell Phone:
Work Phone:	Work Phone:
Home Phone:	Home Phone:
Email Address:	Email Address:

INSURANCE INFORMATION-PLEASE ATTACH A COPY OF THE CARD

Name of Insurance Co.:	Policy Holder Name:
Policy #:	Group #:

PRIMARY PERSON TO CONTACT FOR INJURY/ILLNESS

Name: Check one: ☐ Parent ☐ Guardian ☐ Spouse ☐ Other

Best way to contact: ☐ Cell phone:	☐ Work phone:	☐ Home phone:

CONSENT FOR EVALUATION/EXAMINATION OF PARTICPANTS UNDER 18 YEARS OF AGE

I, _____, being the parent/legal guardian of

_____, give my consent to Skidmore College to administer first aid, triage, and evaluate/treat in an emergency situation. As long as the medical treatment is considered necessary in the situation and it is in accordance with generally accepted standard of medical practice for the type of injury or illness involved, I impose no specific limitations or prohibitions regarding treatment other than those that follow: (If none, so state)

_____

Whenever possible, prior to referring your child/student to an outside medical provider, Skidmore College will make every attempt to contact a parent or guardian.

_____ Date: _____

(Signature of Parent/Legal Guardian/Relationship to Patient)

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Program Name: _____

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REQUIRED HEALTH EXAMINATION/IMMUNIZATION FORM **(performed on or after 7/1/2023)**	**EXAM DATE:**

STUDENT INFORMATION

Participant Name:	Preferred Name:	DOB:
Sex Assigned at birth: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information

☐ **Allergies**	Type: ☐ Medication Order Attached ☐ Anaphylaxis Care Plan Attached
☐ **Asthma**	☐Intermittent ☐ Persistent ☐ Other: ☐ Medication Order Attached ☐ Asthma Care Plan Attached
☐ **Seizures**	Type: Date of last seizure: ☐ Medication Order Attached ☐ Seizure Care Plan Attached
☐ **Diabetes**	Type: ☐ 1 ☐ 2 ☐ Medication Order Attached ☐ Diabetes Mgmt Plan Attached

MEDICATIONS

☐ **Self-Carry/Self-Administer medication form completed, signed, attached (pg. 4)**

DRUG ALLERGIES

Allergies (please list): _____ ☐ No Known Drug Allergies

PHYSICAL EXAMINATION/ASSESSMENT

Height:	**Weight:**	**BP:**	**Pulse:**	**Respirations:**

☐ **System Review Within Normal Limits**

☐ **Abnormal Findings-List Other Pertinent Medical Concerns Below (ex. concussion, mental health, one functioning kidney)**

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine/Neck	☐ Skin	☐ Social Emotional
☐ Mental Health	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations: Additional Information Attached	Diagnoses/Problems (list)
☐ Student may participate in ALL activities without restrictions	☐ If Restrictions apply, please note:

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Program Name: _____

Participant Name:	Preferred Name:	**DOB:**

REQUIRED IMMUNIZATIONS

A. Measles (Rubeola): Two doses of measles or MMR vaccine. Dose #1 must be given within 4 days of first birthday or later and dose #2 at least 28 days after dose #1 2 DOSES REQUIRED ☐ Primary Measles **OR** ☐ MMR vaccine	Dose #1: _____/_____/_____ MM DD YYYY Dose #2: _____/_____/_____ MM DD YYYY
B. Mumps	Dose #1: _____/_____/_____ MM DD YYYY
C. Rubella	Dose #1: _____/_____/_____ MM DD YYYY
Serologic evidence of immunity to measles, mumps, and rubella is acceptable only when copies of laboratory reports are attached.	Date of Measles Immune titer: _____ (attach lab report) Date of Mumps Immune titer: _____ (attach lab report) Date of Rubella Immune titer: _____ (attach lab report)
D. Tetanus (most recent booster):	Dose: _____/_____/_____ MM DD YYYY
E. Men ACWY **OR** ☐ I have read, or have had explained to me, the information about bacterial meningitis disease. I understand the risk of not vaccinating my child and have decided to decline vaccination at this time. _____ Signature of participant or parent/guardian	Dose #1: _____/_____/_____ MM DD YYYY Booster: _____/_____/_____ MM DD YYYY

RECOMMENDED IMMUNIZATIONS

F. Polio (date series completed):	Dose: _____/_____/_____ MM DD YYYY
G. COVID (Date of most recent booster) Manufacturer: _____	Dose: _____/_____/_____ MM DD YYYY
H. Varicella	Dose #1: _____/_____/_____ MM DD YYYY Dose #2: _____/_____/_____ MM DD YYYY
I. Hepatitis B	Dose #1: _____/_____/_____ MM DD YYYY Dose #2: _____/_____/_____ MM DD YYYY Dose #3: _____/_____/____ MM DD YYYY

HEALTHCARE PROVIDER

Healthcare Provider signature:

Provider Name: *(please print)*

Provider Address:

Phone:	**Fax:**

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Program Name:_____

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PROVIDER AUTHORIZATION FOR SELF-CARRY/SELF-ADMINISTER MEDICATION (<18 years old)

Participant Name:	Preferred Name:	DOB:

PROVIDER: Please indicate medication(s) to be self-carried/self-administered (include prescription and over the counter)

Diagnosis: Name of medication: Prescribed dose, frequency, route: Time to be taken: Duration of treatment: Possible side effects: **Student skill level:** (please check if appropriate) ☐ Independent student: student may self-carry/self-administer* Initial below. ☐ I attest student demonstrated ability to self-administer the prescribed medication effectively. *Provider initials: _____	Diagnosis: Name of medication: Prescribed dose, frequency, route: Time to be taken: Duration of treatment: Possible side effects: **Student skill level:** (please check if appropriate) ☐ Independent student: student may self-carry/self-administer* Initial below. ☐ I attest student demonstrated ability to self-administer the prescribed medication effectively. *Provider initials: _____
Diagnosis: Name of medication: Prescribed dose, frequency, route: Time to be taken: Duration of treatment: Possible side effects: **Student skill level:** (please check if appropriate) ☐ Independent student: student may self-carry/self-administer* Initial below. ☐ I attest student demonstrated ability to self-administer the prescribed medication effectively. *Provider initials: _____	Diagnosis: Name of medication: Prescribed dose, frequency, route: Time to be taken: Duration of treatment: Possible side effects: **Student skill level:** (please check if appropriate) ☐ Independent student: student may self-carry/self-administer* Initial below. ☐ I attest student demonstrated ability to self-administer the prescribed medication effectively. *Provider initials: _____

HEALTHCARE PROVIDER

Healthcare Provider signature:	
Provider Name: *(please print)*	
License #:	
Provider Address:	
Phone:	**Fax:**

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Program Name:_____

PARENTS/GUARDIANS:
READ AND COMPLETE THE AUTHORIZATION FOR SELF CARRY/SELF ADMINISTRATION OF MEDICATION

BY SIGNING THE FORM BELOW, I AGREE TO THE FOLLOWING:

1. I understand that:
    - I must provide all of my student's medication.
    - ALL prescription and 'over the counter' medicine will be the original bottle or box with a valid expiration date.
        - Prescription medicine must have the original pharmacy label on the box or bottle. The label must include:
            1. Student name
            2. Pharmacy name/phone number
            3. Prescriber's name
            4. Date
            5. Number of refills
            6. Name of medicine
            7. Dosage
            8. When to take the medicine
            9. How to take the medicine
            10. Any other instructions.
2. I assume responsibility that my student is storing, carrying and taking their medication as ordered.
3. I must immediately inform the program about any change in my student's medicine or health provider's instructions.
4. For the purposes of providing care or treatment to my student, Skidmore College may obtain any other information they think is needed about my student's condition, medication, or treatment. The Skidmore College may obtain this information from any health care provider, nurse, or pharmacist who has given my student health services.

FOR SELF ADMINISTRATION OF MEDICINE:

I certify that my student has been fully trained and can take medicine independently. I consent to my student carrying, storing, and self-administering the medicine prescribed by my student's healthcare provider. I am responsible for giving my student this medicine in bottles or boxes as described above.

Participant Last Name:	Participant First Name:	DOB:

Parent Guardian Name *(Print):*		
Parent/Guardian Signature:		
Parent Guardian Address:		
Parent/Guardian Email:		
Parent/Guardian Telephone Numbers:	Daytime:	Cell:
Date Signed:		

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Program Name: _____

Participant Name:	DOB:

SCREENING FOR TUBERCULOSIS REQUIRED

Parent/Guardian: Please answer the tuberculosis screening questions below and sign where indicated (any 'YES' answers requires tuberculosis testing):

1. Does the participant have any signs or symptoms of active pulmonary tuberculosis? (Coughing for 3 weeks or longer with or without sputum production, chest pain, unexplained weight loss, fever, coughing up blood, loss of appetite, or night sweats?	☐ Yes ☐ No
2. Was the participant born in OR had frequent or prolonged visits (> 3 weeks) to Africa, Asia (including China and Korea), Eastern Europe or Latin America?	☐ Yes ☐ No
3. Does the participant have a history of positive PPD skin test or IGRA blood test?	☐ Yes ☐ No
4. Has the participant ever had close contact with persons known or suspected to have active TB disease?	☐ Yes ☐ No
5. Has the participant been a resident and/or employee of high-risk congregate setting (ex. Correctional facilities, long term care facilities, homeless shelter) or served clients at high risk for active TB disease?	☐ Yes ☐ No
6. Is the participant a member of any of the following groups that may have an increased incidence of latent tuberculosis infection or active TB disease-medically underserved, low-income, or abusing drugs or alcohol?	☐ Yes ☐ No

Signature of Parent/Guardian: _____ Date: _____

Tuberculosis Testing-only needed if answered 'yes' to any questions above

Participants who answered 'yes' to any of the above screening questions must **schedule an appointment with their healthcare provider** to have tuberculosis testing. Testing is **REQUIRED** to be performed after 7/1/2023.

Testing can be performed by QuantiFERON Gold testing **OR** PPD (QFT is preferred)

QUANTIFERON GOLD

Date Collected: _____ Result: ☐ Negative ☐ Positive* ☐ Indeterminate

*Positive results require a follow up chest x-ray

PPD TESTING

Date placed: _____ Date Read: _____

Result: _____ mm of induration Interpretation: ☐ Positive* ☐ Negative

*Positive results require a follow up chest x-ray

CHEST X-RAY (If QFT or PPD positive, there is past history of positive tuberculosis test, or patient is experiencing symptoms of tuberculosis)

Date: _____ Results: ☐ Normal ☐ Abnormal

PREVENTATIVE OR THERAPEUTIC TUBERCULOSIS TREATMENT, if indicated

Medication(s): Please List_____ Dates taken: _____

HEALTHCARE PROVIDER SIGNATURE

Healthcare Provider signature:	
Healthcare Provider Name (please print):	
Provider Address:	
Phone:	**Fax:**

SKIDMORE COLLEGE

Frequently Asked Questions and Answers About Meningococcal Meningitis

What is meningococcal disease?

Meningococcal disease is caused by bacteria called *Neisseria meningitidis*. It can lead to a serious blood infection called meningococcal septicemia. When the linings of the brain and spinal cord become infected, it is called meningococcal meningitis. The disease strikes quickly and can have serious complications, including death.

Anyone can get meningococcal disease. Some people are at higher risk. This disease occurs more often in people who are:

- Teenagers or young adults
- Infants younger than one (1) year of age
- Living in crowded settings, such as college dormitories or military barracks
- Traveling to areas outside of the United States, such as the "meningitis belt" in Africa
- Living with a damaged spleen or no spleen or have sickle cell disease
- Living with HIV
- Being treated with the medication Soliris® or Ultomiris™, or those who have complement component deficiency (an inherited immune disorder)
- Exposed during an outbreak
- Working with meningococcal bacteria in a laboratory
- Recently infected with an upper respiratory virus
- Smokers

What are the symptoms?

Symptoms appear suddenly – usually three (3) to four (4) days after a person is infected. It can take up to ten (10) days to develop symptoms. Symptoms of meningococcal meningitis may include:

- Fever
- Headache
- Stiff neck
- Nausea
- Vomiting
- Photophobia (eyes being more sensitive to light)
- Altered mental status (confusion)

Newborns and babies may not have the classic symptoms listed above, or it may be difficult to notice those symptoms in babies. Instead, babies may be slow or inactive, irritable, vomiting, feeding poorly, or have a bulging anterior fontanelle (the soft spot of the skull). In young children, doctors may also look at the child's reflexes for signs of meningitis.

Symptoms of meningococcal septicemia may include:

- Fever and chills
- Fatigue (feeling tired)
- Vomiting
- Cold hands and feet
- Severe aches or pains in the muscles, joints, chest, or abdomen (belly)
- Rapid breathing
- Diarrhea
- In the later stages, a dark purple rash

How is meningococcal disease spread?

It spreads from person-to-person by coughing or coming into close or lengthy contact with someone who is sick or who carries the bacteria. Contact includes kissing, sharing drinks, or living together. Up to one (1) in 10 people carry meningococcal bacteria in their nose or throat without getting sick.

Is there treatment?

Early diagnosis of meningococcal disease is very important. If it is caught early, meningococcal disease can be treated with antibiotics. However, sometimes the infection has caused too much damage for antibiotics to prevent death or serious long-term problems. Most people need to be cared for in a hospital due to the serious, life-threatening nature of this infection.

What are the complications?

10-15% of those who get meningococcal disease die. Among survivors, as many as one (1) in five (5) will have permanent disabilities. Complications include:

- Hearing loss
- Brain damage
- Kidney damage
- Nervous system problems
- Limb amputations

What should I do if I or someone I love is exposed?

If you are in close contact with a person with meningococcal disease, talk with your healthcare provider about the risk to you and your family. They can prescribe an antibiotic to prevent the disease.

What is the best way to prevent meningococcal disease?

The single best way to prevent this disease is to be vaccinated. Vaccines are available for people six (6) weeks of age and older. Various vaccines offer protection against the five (5) major strains of bacteria that cause meningococcal disease:

- All preteens and teenagers should receive two doses of vaccine against strains A, C, W and Y, also known as MenACWY or MCV4 vaccine. The first dose is given at 11 to 12 years of age, and the second dose (booster) at 16 years. It is very

important that teens receive the booster dose at age 16 years in order to protect them through the years when they are at greatest risk of meningococcal disease.

- Teens and young adults can also be vaccinated against the "B" strain, also known as MenB vaccine. Talk to your healthcare provider about whether they recommend vaccine against the "B" strain.

Who should not be vaccinated?

Some people should avoid or delay the meningococcal vaccine:

- Tell your doctor if you have any severe allergies. Anyone who has ever had a severe allergic reaction to a previous dose of meningococcal vaccine should not get another dose of the vaccine.
- Anyone who has a severe allergy to any component in the vaccine should not get the vaccine.
- Anyone who is moderately or severely ill at the time the shot is scheduled should wait until they are better. People with a mild illness can usually get vaccinated.

What are the meningococcal vaccine requirements for school attendance?

- For students entering grades seven (7) through 11: one dose of MenACWY vaccine
- For students entering grade 12: two (2) doses of MenACWY vaccine
    - The second dose needs to be given on or after the 16th birthday.
    - Teens who received their first dose on or after their 16th birthday do not need another dose.

Reference

Health, N. Y. (2023, January). *Meningococcal Disease Fact Sheet*. Retrieved from New York State Department of Health Communicable Disease: https://www.health.ny.gov/publications/2168/