Dear Summer Staff,  

We at Health Services are pleased that you will be here this summer! This memo is to stress the importance and timeliness of completing the enclosed Health Assessment Form.

Health Services provides first aid to summer program staff that is not enrolled as a Skidmore student. For more complex issues, we can offer assistance in finding an appropriate community provider, including Wilton Medical Arts Urgent Care and Saratoga Hospital located within 5 minutes of campus.

It is requested that the enclosed Health Assessment Form be completely and accurately filled out and submitted to your Program Director prior to arriving on campus. Immunization information is requested for the public health and safety of the campus and the participants. Without documentation of immunity, staff may be asked to leave in the event of an outbreak. There is a ‘Summer Programs Nurse’ to assist you with the form, and answer any questions you may have. A message can be left for Michelle Lapo, RN, at (518) 580-5550, or by e-mail at mlapo@skidmore.edu.

Although not required, if you are working with children and have not had chicken pox, the varicella vaccine is recommended for your protection. Additionally, Hepatitis B vaccine is recommended if you will be responsible for providing any first aid to program participants.

Saratoga Springs is delightful in the summer, and we are happy that you will be here. We wish you a safe, happy, and healthy summer experience.

Sincerely,

Health Services Staff
Instructions:

1. This 4 page form must be returned to your summer program director prior to arrival at the college. **Immunizations are requested for the public health and safety of the campus and the participants. Without documentation of immunity, staff may be asked to leave campus in the event of an outbreak.**
2. Page 1 should be filled out prior to going to your health care provider.
3. Page 2, 3, and 4 should be completed by your non-parental health care provider.

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**STAFF INFORMATION:**

Name of Summer Program:____________________________________________________

Name:_________________________________________ Date of Birth: ____________________

( Last, First) (MM/DD/YYYY)

Home Address:_________________________________________

Street City State Zip Country

Gender: □ Male □ Female □ Other_________________ Staff Cell Phone #:_________________

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**Parent/Guardian #1 Name:**

Address:_________________________________________

Home Phone:__________________________________ Work Phone:__________________________________

Cell Phone:__________________________________ Email Address:____________________

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**Parent/Guardian #2 Name:**

Address:_________________________________________

Home Phone:__________________________________ Work Phone:__________________________________

Cell Phone:__________________________________ Email Address:____________________

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**PRIMARY PERSON TO CONTACT FOR CONSENT: FOR TREATMENT OR IN CASE OF AN EMERGENCY**

Name:_________________________________________ Check one: □ Parent □ Legal Guardian □ Spouse □ Other____________________

Address:_________________________________________

Home Phone:__________________________________ Business Phone:__________________________________

Cell Phone:__________________________________ Email Address:____________________

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**INSURANCE INFORMATION**

Insurance Co.:________________________________ Policy Holder’s Name:____________________

Address:________________________________________ Telephone:____________________

Policy #:________________________________ Group #:____________________
### IMMUNIZATION RECORD:

A. **MEASLES** (Rubeola): *Two doses of measles or MMR immunizations are required.*

Dose #1 must be given within 4 days of first birthday or later and dose #2 at least 28 days after dose #1. Serologic evidence of immunity to measles, mumps, and rubella is acceptable when copies of laboratory reports are attached.

| PRIMARY MEASLES or MMR immunization:          | #1   | #2   |
|                                            | MM   | DD   | YYYY | MM   | DD   | YYYY |

B. **MUMPS**: Two doses of mumps or MMR immunization are recommended.

| #1   | #2   |
| MM   | DD   | YYYY | MM   | DD   | YYYY |

C. **RUBELLA**:

| #1   | #2   |
| MM   | DD   | YYYY | MM   | DD   | YYYY |

D. **HEPATITIS B**:

| #1   | #2   | #3   |
| MM   | DD   | YYYY | MM   | DD   | YYYY | MM   | DD   | YYYY |

E. **TETANUS-DIPHTHERIA** (latest booster):

| MM   | DD   | YYYY |

F. **POLIO** (Date of completion of primary series):

| MM   | DD   | YYYY |

G. **VARICELLA**:

| #1   | #2   |
| MM   | DD   | YYYY | MM   | DD   | YYYY |

-OR-

**History of Chickenpox Disease** □ Yes □ No

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### HEALTH CARE PROVIDER SIGNATURE:

Provider Name: ___________________________  Address: ___________________________

Provider Signature: ___________________________  ___________________________

Date signed: ___________________________  Phone: ( ) ___________________________

Fax: ( ) ___________________________
SECTION I - TUBERCULOSIS (TB) SCREENING

To Be Completed By Summer Staff and Their Health Care Provider Within 6 Months Prior to The Participant’s Arrival on Campus (Health Care Provider’s Signature REQUIRED on the Page 4 of this Form)

-TUBERCULOSIS SCREENING AND RISK ASSESSMENT QUESTIONNAIRE -

1) Has the patient ever had a positive TB test?  
   - Yes  
   - No  
   - Unknown

2) Has the patient had recent close contact with someone with infectious TB disease?  
   - Yes  
   - No  
   - Unknown

3) Was the patient born in or have they traveled to/in a high-prevalence TB area within the past 5 years?  
   - Yes, patient at high risk  
   - Yes, but patient at low risk  
   - No  
   (See list of high-prevalence countries below. The significance of the possible travel exposure should be evaluated.)

   **Countries with High Prevalence of Tuberculosis**
   - Afghanistan
   - Algeria
   - Angola
   - Anguilla
   - Argentina
   - Armenia
   - Azerbaijan
   - Bahamas
   - Bahrain
   - Bangladesh
   - Belarus
   - Belize
   - Benin
   - Bhutan
   - Bolivia
   - Bosnia & Herzegovina
   - Botswana
   - Brazil
   - Brunei Darussalam
   - Bulgaria
   - Burkina Faso
   - Burundi
   - Cambodia
   - Cameroon
   - Cape Verde
   - Central African Republic
   - Chad
   - China
   - Colombia
   - Comoros
   - Congo

   - Congo DR
   - Cote d’Ivoire
   - Croatia
   - Djibouti
   - Dominican Republic
   - Ecuador
   - Egypt
   - El Salvador
   - Equatorial Guinea
   - Eritrea
   - Ethiopia
   - Fiji
   - French Polynesia
   - Gabon
   - Gambia
   - Georgia
   - Ghana
   - Guam
   - Guinea
   - Guinea-Bissau
   - Guyana
   - Haiti
   - Honduras
   - Indonesia
   - Iran
   - Iraq
   - Japan
   - Kazakhstan
   - Kenya
   - Kiribati
   - Korea-DPR
   - Korea-Republic
   - Kuwait
   - Kyrgyzstan
   - Lao PDR
   - Latvia
   - Lithuania
   - Macedonia
   - Madagascar
   - Malawi
   - Maldives
   - Mali
   - Malaysia
   - Maldives
   - Mauritania
   - Mauritius
   - Micronesia
   - Moldova
   - Mongolia
   - Montenegro
   - Morocco
   - Mozambique
   - Myanmar
   - Namibia
   - Nepal
   - Nicaragua
   - Niger
   - Nigeria
   - Niue
   - Nauru
   - N. Mariana Islands
   - New Caledonia
   - New Zealand
   - Netherlands
   - Nigeria
   - Nicaragua
   - Nepal
   - Norway
   - Pakistan
   - Palau
   - Panama
   - Paraguay
   - Peru
   - Philippines
   - Poland
   - Portugal
   - Qatar
   - Russian Federation
   - Rwanda
   - Saint Vincent & The Grenadines
   - Samoa
   - Sao Tome & Principe
   - Senegal
   - Serbia
   - Sheldon
   - Singapore
   - South Africa
   - Spain
   - Sri Lanka
   - Sudan
   - Suriname
   - Syria
   - Syrian Arab Republic
   - Taiwan
   - Tanzania
   - Thailand
   - Timor-Leste
   - Togo
   - Trinidad & Tobago
   - Turks & Caicos Islands
   - Tuvalu
   - Turkey
   - Turkmenistan
   - Ukraine
   - United Arab Emirates
   - United Kingdom
   - United States
   - Uruguay
   - Uzbekistan
   - Vanuatu
   - Venezuela
   - Viet Nam
   - Wallis & Futuna Islands
   - Yemen
   - Zambia
   - Zimbabwe

4) Does the patient have any of the following:  
   - Fibrotic changes on a prior chest x-ray suggesting inactive or past TB disease?  
     - Yes  
     - No  
     - Unknown
   - HIV/AIDS?  
     - Yes  
     - No  
     - Unknown
   - Organ transplant recipient?  
     - Yes  
     - No  
     - Unknown
   - Immunosuppressed?  
     - Yes  
     - No  
     - Unknown
   - History of illicit drug use?  
     - Yes  
     - No  
     - Unknown
   - Resident, employee or volunteer in a high-risk setting (e.g., correctional facility, nursing home, homeless shelter, hospital or other health care facility)?  
     - Yes  
     - No
   - Medical condition associated with increased risk of progressing to TB disease if infected (e.g., diabetes mellitus, silicosis, head/neck/lung cancer, hematologic or reticuloendothelial disease such as Hodgkin’s or leukemia, end stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight)?  
     - Yes  
     - No

5) Does the patient have signs or symptoms of active TB disease?  
   - Yes  
   - No

**If the answer is YES to any of the above questions, patient is considered to be in a high risk group**

**If the answer to all above questions is NO, patient is considered to be at low risk**

PROCEED TO PAGE 4 OF THIS FORM
As determined by review of the Section I screening questionnaire on Page 3, this PATIENT IS CONSIDERED (please check appropriate box):

☐ at Low Risk for tuberculosis – proceed directly to Section III below – PROVIDER SIGNATURE
☐ at High Risk for tuberculosis – proceed to Section II and III below – TB TESTING, PROVIDER SIGNATURE

SECTION II – TUBERCULOSIS (TB) TESTING

Persons with any of the risk factors listed on the page 3 of this form are candidates for either Mantoux or PPD tuberculin skin testing (TST) OR Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented. If the patient has had a previous positive tuberculin skin test or IGRA, then a chest x-ray documenting a “normal” result is REQUIRED before patient’s arrival on campus. (proceed directly to item #3).

Please note: a history of BCG vaccination should NOT preclude testing of a member of a high risk group.

1. Tuberculin Skin Test (TST) – PPD or Mantoux

TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write “0”. The TST interpretation should be based on mm of induration as well as risk factors.

Date Given: _____/_____/_____
Date Read: ______/_____/_____

Result: ________ mm of induration
Interpretation: positive ___ negative ___

2. Interferon Gamma Release Assay (IGRA)

Date Obtained: _____/_____/_____
(specify method) □ QFT-G □ QFT-GIT ☐ other ________

Result:

M      D       Y
negative ___ positive ___ indeterminate ___

Date Obtained: _____/_____/_____
(specify method) □ QFT-G □ QFT-GIT ☐ other ________

Result:

M      D       Y
negative ___ positive ___ indeterminate ___

3. Chest X-Ray: Required prior to patient’s arrival on campus if either the TST or IGRA result is positive or there is a past history of a positive tuberculosis test

Date of chest x-ray: _____/_____/_____
Result: normal ___ abnormal ___

M       D      Y

4. Preventive or Therapeutic Tuberculosis Treatment

Medication(s) – Please List:

________________________________________________________________________ Dates Taken: ______________________________________________________________________
________________________________________________________________________ Dates Taken: ______________________________________________________________________
________________________________________________________________________ Dates Taken: ______________________________________________________________________

SECTION III - PROVIDER INFORMATION and SIGNATURE REQUIRED:

(Print) Name and Title/Degree of Health Care Provider

Address: (Please print or stamp)

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Provider Signature

Date Signed: ______________________________________________________________________

Phone: ( ________)

Fax: ( ________)

________________________________________________________________________