

# SKIDMORE

C O L L E G E

## HEALTH SERVICES Incoming Student Requirements 2025-2026

- Requirements must be submitted by July 15, 2025.
- Required paper forms are attached.
- Electronic steps & forms can be completed via the Health Services Portal. Login is via single sign-on. <https://skidmore.studenthealthportal.com/Account/Logon>
- Paper forms should be uploaded to portal individually with appropriate “document type” selected

### GUIDE TO ATTACHED FORMS:

#### Part A: Immunization Form/Record

Required immunizations include:

- **MMR** (Measles, Mumps & Rubella) vaccines – 1st dose given on or after 1st birthday. 2nd dose required at least 28 days after 1st dose
- **Td or Tdap** – Tetanus, Diptheria, & Pertussis vaccine: Required within the last 10 years
- **Meningitis** (Menactra, Menquadfi or Menveo – ACWY) within the last 5 years

#### Part B: Physical Exam Form

- Exam performed on or after July 15, 2023. If you have not had a physical exam in this time frame, please schedule with your primary care provider: Print and bring this form to the appointment.
- Alternative physical exam documentation may be accepted and must include 1) documentation of a physical exam 2) pertinent clinical findings with clearance for sports participation and 3) signature of medical provider.

### CHECKLIST:

Requirement	Format	Completed by	Completed	Uploaded to portal
Part A: Immunization Record	<b>Paper form</b>	Medical provider	<input type="checkbox"/>	<input type="checkbox"/>
Part B: Physical Exam Form	<b>Paper form</b>	Medical provider	<input type="checkbox"/>	<input type="checkbox"/>
Part C: Tuberculosis Screening Questionnaire & Testing	Electronic form	Student and, medical provider (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>
Health History Questionnaire	Electronic form	Student	<input type="checkbox"/>	N/A
Contact Information & Text Messages Consent	Electronic form	Student	<input type="checkbox"/>	N/A
Informed Consent for Integrated Care * (Note: Students under 18 may not have this available until Summer 2025. Please recheck "My Forms" at a later date.)	Electronic form	Student	<input type="checkbox"/>	N/A
Understanding of Use and Privacy*	Electronic form	Student	<input type="checkbox"/>	N/A
Health insurance plan information & <b>upload copy of card</b>	Electronic form + upload	Student	<input type="checkbox"/>	<input type="checkbox"/>

\* For students under 18, these forms will need to be completed again once the student turns 18.

**\*\*NCAA VARSITY ATHLETES REQUIRE ADDITIONAL PAPERWORK\*\***

**SEE WEBSITE FOR DETAILS**

<https://www.skidmore.edu/health-services/forms/NCAAStudentAthletes.php>



## PART A: IMMUNIZATION RECORD

STUDENT NAME: \_\_\_\_\_

DATE OF BIRTH (mm/dd/yy): \_\_\_/\_\_\_/\_\_\_

**REQUIRED IMMUNIZATIONS** date format (mm/dd/yy)

**MEASLES, MUMPS, RUBELLA REQUIREMENT –ONE of the following options - NYS Department of Health Law**

**OPTION 1: MMR (Measles, Mumps, & Rubella) combo vaccine**

- 1st dose required after 1st birthday and
- 2nd dose required at least 28 days after 1st dose

MMR #1: \_\_\_/\_\_\_/\_\_\_

MMR #2: \_\_\_/\_\_\_/\_\_\_

**OPTION 2: Separate vaccines (4 in total)**

**Measles**

- 1st dose required after 1st birthday **AND**
- 2nd dose required at least 28 days after 1st dose **AND**

Measles #1: \_\_\_/\_\_\_/\_\_\_

Measles #2: \_\_\_/\_\_\_/\_\_\_

**Mumps**

- 1 dose required after 1st birthday **AND**

Mumps #1: \_\_\_/\_\_\_/\_\_\_

**Rubella**

- 1 dose required after 1st birthday

Rubella #1: \_\_\_/\_\_\_/\_\_\_

**OPTION 3: Antibody titers for measles, mumps, rubella**

- Attach lab reports

Measles Titer: \_\_\_/\_\_\_/\_\_\_

Mumps Titer: \_\_\_/\_\_\_/\_\_\_

Rubella Titer: \_\_\_/\_\_\_/\_\_\_

**MENINGITIS - MENACTRA, MenQuadfi or MENVEO (ACWY)**

- At minimum 1 dose within the last 5 years.

Meningitis: \_\_\_/\_\_\_/\_\_\_

\*Men B does not meet this requirement

**TETANUS-DIPHTHERIA-PERTUSSIS— Td or Tdap Required within last 10 years**

Td : \_\_\_/\_\_\_/\_\_\_

Tdap: \_\_\_/\_\_\_/\_\_\_

**RECOMMENDED IMMUNIZATIONS** date format (mm/dd/yy)

**MENINGOCOCCAL B**

**Bexsero**

Men B #1: \_\_\_/\_\_\_/\_\_\_

Men B #2: \_\_\_/\_\_\_/\_\_\_

**Trumenba**

Men B #1: \_\_\_/\_\_\_/\_\_\_

Men B #2: \_\_\_/\_\_\_/\_\_\_

Men B #3: \_\_\_/\_\_\_/\_\_\_

OR

Hepatitis A #1: \_\_\_/\_\_\_/\_\_\_

Hepatitis A #2: \_\_\_/\_\_\_/\_\_\_

Hepatitis B #1: \_\_\_/\_\_\_/\_\_\_

Hepatitis B #2: \_\_\_/\_\_\_/\_\_\_

Hepatitis B #3: \_\_\_/\_\_\_/\_\_\_

**HPV (Human Papilloma Virus)**

Gardasil #1: \_\_\_/\_\_\_/\_\_\_

Gardasil #2: \_\_\_/\_\_\_/\_\_\_

Gardasil #3: \_\_\_/\_\_\_/\_\_\_

**POLIO**

Primary series completed:

\_\_\_/\_\_\_/\_\_\_ (circle one) **IPV OPV**

Additional dose post

completion of primary series

(if applicable): \_\_\_/\_\_\_/\_\_\_

**OTHER IMMUNIZATION**

(most recent date)

**Rabies** (date series completed)

\_\_\_/\_\_\_/\_\_\_

**Typhoid** (injectable) \_\_\_/\_\_\_/\_\_\_

**Typhoid** (Oral) \_\_\_/\_\_\_/\_\_\_

**Yellow Fever** \_\_\_/\_\_\_/\_\_\_

**VARICELLA (Chickenpox)**

Varicella #1: \_\_\_/\_\_\_/\_\_\_

Varicella #2: \_\_\_/\_\_\_/\_\_\_

OR

History of Chickenpox:

\_\_\_ Yes, Date: \_\_\_\_\_

\_\_\_ No

**COVID**

Date of most recent

vaccine:

\_\_\_/\_\_\_/\_\_\_

Manufacturer:

**STATEMENT OF EXEMPTION TO NEW YORK STATE IMMUNIZATION LAW**

Religious Exemption

Medical Exemption

Required supporting documentation must be provided as specified on the Health Services website.

<https://www.skidmore.edu/health-services/ImmunizationRequirementsandExemption.php>

**PROVIDER INFORMATION & SIGNATURE REQUIRED**

\_\_\_\_\_  
Name & Title of Healthcare Provider (please print)

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address (print or stamp)

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

## PART B: PHYSICAL EXAM FORM

<b>LAST NAME:</b>		<b>FIRST NAME:</b>		<b>DATE OF BIRTH:</b>	
<b>VITAL SIGNS:</b>	<b>Ht:</b>	<b>Wt:</b>	<b>BP:</b>	<b>Pulse:</b>	

**MEDICATIONS:**

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**ALLERGIES:**

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**PAST MEDICAL HISTORY:**

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ITEM/AREA EVALUATED	NORMAL	NOT EXAMINED	ABNORMAL	IF ABNORMALITIES ARE NOTED, PLEASE DESCRIBE
Appearance				
Nose & Sinuses				
Mouth & Throat				
Teeth & Gingiva				
Ears				
Eyes				
Neck				
Lungs				
Heart				
Vascular				
Abdomen				
Upper Extremities				
Lower Extremities				
Spine				
Neurologic				
Other (please specify)				

### MEDICAL PROVIDER ATTESTATION

**FOR ALL INCOMING STUDENTS:**

I have examined this patient within the past 2 years (AFTER 7/15/2023\*). All medical/psychiatric conditions and therapies are noted above or on attached pages.

**\*FOR STUDENTS PARTICIPATING IN NCAA ATHLETICS EXAM MUST BE WITHIN 6 MONTHS OF PARTICIPATION (ON or AFTER 3/1/2025 for students joining team Fall 2025) per NCAA requirements**

- Cleared for all sports without restriction based on physical exam (\*Note: Sports Health History Form must also be reviewed and signed by provider)
- Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_
- Not cleared due to: \_\_\_\_\_

Additional recommendations/comments:

**Provider Name (Print):** \_\_\_\_\_ **Date of Exam:** \_\_\_\_\_

**Signature of Medical Provider:** \_\_\_\_\_ **Provider credentials:** \_\_\_\_\_

**Provider Address, Phone Number, Fax number (Please print or stamp):**

**Phone # (\_\_\_\_) \_\_\_\_\_ Fax # (\_\_\_\_) \_\_\_\_\_**