



SKIDMORE COLLEGE HEALTH SERVICES

815 North Broadway, Saratoga Springs, NY 12866

Phone: 518-580-5550

Fax: 518-580-5556

e-mail: health@skidmore.edu

INCOMING STUDENT REQUIREMENTS 2026-2027

- Requirements must be submitted by July 15, 2026.
- Electronic forms are available through your MyWellness Portal. Please see the Health Services website with questions.
- Paper forms and images of your insurance card (front and back) must be uploaded to the appropriate portal sections.

REQUIRED PAPER FORMS (see attached guide for paper forms)

Immunization Form with Records

Required immunizations include:

- **MMR** (Measles, Mumps & Rubella): First dose on or after 1st birthday; second dose at least 28 days after first dose.
- **Td or Tdap** (Tetanus, Diphtheria, & Pertussis) within the last 10 years
- **Meningitis: ACWY** (Menactra, MenQuadfi, Menveo) **or** **ABCWY** (Penbraya, Penmenv) within the last 5 years

Within the portal, you will be prompted to enter the dates of each immunization and upload supporting documentation. One immunization record containing all required vaccines is acceptable.

“Recommended Immunizations” are optional but strongly encouraged, as they may be important for future medical care, academic programs or employment requirements.

Physical Exam Form

- A physical exam completed on or after **July 15, 2024** is required. If needed, schedule an appointment with your primary care provider: Print and bring the form with you.
- Alternative documentation may be accepted if it includes: 1) Documentation of a physical exam 2) Pertinent clinical findings with clearance for sports participation and 3) Signature of a licensed medical provider.

CHECKLIST:

Under “Forms & Requirements” in MyWellness Portal	Format	Completed by	Completed	Uploaded to portal
Health History	Electronic form	Student	<input type="checkbox"/>	N/A
Immunization Record	Paper form	Medical provider	<input type="checkbox"/>	<input type="checkbox"/>
Integrated Consent*	Electronic form	Student	<input type="checkbox"/>	N/A
Notice of Privacy Practices*	Electronic form	Student	<input type="checkbox"/>	N/A
Physical Exam	Paper form	Medical provider	<input type="checkbox"/>	<input type="checkbox"/>
Home Provider(s) Contact Info	Electronic form	Student	<input type="checkbox"/>	N/A
Understanding of Use and Privacy*	Electronic form	Student	<input type="checkbox"/>	N/A
Tuberculosis Screening Questionnaire & Testing (if applicable)	Electronic form	Student and, medical provider (if applicable)	<input type="checkbox"/>	<input type="checkbox"/> (if applicable)
Under “Insurance Details” in MyWellness Portal: Health insurance plan information and upload copy of card (front & back)	Electronic form + upload	Student	<input type="checkbox"/>	<input type="checkbox"/>

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

SEE WEBSITE FOR DETAILS

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



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



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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 given no more than 4 days prior to 1st birthday and
• 2nd dose given at least 28 days after 1st dose

MMR #1: __/__/__

MMR #2: __/__/__

OPTION 2: Separate vaccines (4 in total)

Measles (2 doses)

- 1st dose given no more than 4 days prior to 1st birthday AND
• 2nd dose given at least 28 days after 1st dose AND

Measles #1: __/__/__

Measles #2: __/__/__

Mumps

- Single dose given no more than 4 days prior to 1st birthday AND

Mumps #1: __/__/__

Rubella

- Single dose given no more than 4 days prior to 1st birthday

Rubella #1: __/__/__

OPTION 3: Antibody titers for measles, mumps, rubella

- Attach lab reports

Measles Titer: __/__/__

Mumps Titer: __/__/__

Rubella Titer: __/__/__

MENINGITIS – ACWY (Menactra, MenQuadfi, Menveo) OR ABCWY (Penbraya, Penmenvy)

- At minimum 1 dose within 5 years of the first day of classes
*Men B alone does not meet this requirement

Meningitis: __/__/__

TETANUS-DIPHTHERIA-PERTUSSIS— Td or Tdap Required within 10 years of the first day of classes

Td : __/__/__

Tdap: __/__/__

RECOMMENDED IMMUNIZATIONS date format (mm/dd/yy)

Table with 4 columns: MENINGOCOCCAL B, Hepatitis A/B, HPV, and POLIO. Each column contains vaccination options and dates.

OTHER IMMUNIZATION (most recent date)

Rabies (date series completed) __/__/__ Typhoid (Oral) __/__/__
Yellow Fever __/__/__ Typhoid (Inj) __/__/__

VARICELLA (Chickenpox)

Varicella #1: __/__/__ History of disease:
Varicella #2: __/__/__ OR Date: _____

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/policies/ImmunizationRequirementsandExemption.php

PROVIDER INFORMATION & SIGNATURE REQUIRED

Name & Title of Healthcare Provider (please print)

Provider Signature Date

Address (print or stamp)

Phone: (____) _____ Fax: (____) _____



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PHYSICAL EXAM FORM

LAST NAME: FIRST NAME: DATE OF BIRTH:

VITAL SIGNS: Ht: Wt: BP: Pulse:

PAST MEDICAL HISTORY (or attach EMR documentation):

Table with 5 columns: ITEM/AREA EVALUATED, NORMAL, NOT EXAMINED, ABNORMAL, IF ABNORMALITIES ARE NOTED, PLEASE DESCRIBE. Rows include Appearance, Nose & Sinuses, Mouth, Throat, Dentition, 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 7/15/2024*). 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 3/1/2026 for students joining team Fall 2026) 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 # ()