SKIDMORE
COLLEGE

Spring, 2025

Dear Summer Staff,

The Office of Special Programs is pleased to be working with you this summer! This letter is to stress the importance and timeliness of completing the enclosed Health Assessment Form.

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. Please follow the instructions that are at the top of Page 1.

As of April 10, 2025, there have been over 700 confirmed cases of measles in 24 states. Exposure to measles in absence of vaccination requires either immunization or leaving campus. It is **highly recommended** that you submit documentation of measle, mumps, and rubella vaccination. Hepatitis B series is highly recommended if you are working in a position that includes administering first aid and potential exposure to blood.

We are happy to have you here on campus and hope you enjoy your summer in Saratoga Springs!

Sincerely,

SKIDMORE COLLEGE | Office of **Special Programs**

SKIDMORE COLLEGE

2025 Summer Staff Health Form (Page 1)

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

Program Name:_____

INSTRUCTIONS		
1. This 3 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 or be immunized in the event of an outbreak.** **NOTE: As of April 10, 2025, there have been over 700 confirmed cases of measles in 24 states.** 2. Page 2 may be completed independently if you have a copy of your immunization record (Please attach copy. Immunization record should include your name, DOB, name of the physician or practice that keeps your records) OR may be completed by your healthcare provider. 3. Please answer the questions on Page 3. Follow the instructions to determine if you need tuberculosis testing by your healthcare provider.		
STAFF INFORMATION:		
Name: (last, first)	Preferred Name:	DOB:
Home Address: Street City State Zip Country		
Cell Phone #:		
EMERGENCY CONTACT		
Name:	**Check one:** ☐Spouse ☐Parent ☐Guardian ☐Other	
Home Address: Street City State Zip Country		
Home Phone:	Work Phone:	
Cell Phone:	Email:	
INSURANCE INFORMATION		
Name of Insurance Co.:	Policy Holders Name:	
Policy Number:	Group Number:	

SKIDMORE COLLEGE

Program Name:_____

2025 Summer Staff Health Form (Page 2)
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Staff Name: (Last, First)	Preferred Name:	DOB:

RECOMMENDED VACCINES

1. **MEASLES (Rubeola):** Two doses of measles or MMR are recommended.
   First dose should be given no sooner than 4 days before first birthday and second dose at least 28 days after dose #1

Primary Measles or MMR immunization: (please circle type)	Dose #1: (MM/DD/YYYY)	Dose #2: (MM/DD/YYYY)

2. **MUMPS:** One or two doses of mumps or MMR are recommended

Primary Mumps or MMR immunization: (please circle type)	Dose #1: (MM/DD/YYYY)	Dose #2: (MM/DD/YYYY)

3. **RUBELLA:** One or two doses of rubella or MMR are recommended

Primary Rubella or MMR immunization: (please circle type)	Dose #1: (MM/DD/YYYY)	Dose #2: (MM/DD/YYYY)

Serologic evidence of immunity to measles, mumps, and rubella is acceptable when copies of lab 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)

4. **HEPATITIS B**	Dose #1: (MM/DD/YYYY)	Dose #2: (MM/DD/YYYY)	Dose #3: (MM/DD/YYYY)
5. **TETANUS -DIPTHERIA** (most recent booster within the last 10 years)			Dose: (MM/DD/YYYY)
6. **COVID-19:** (most recent dose) Manufacturer:			Dose: (MM/DD/YYYY)
7. **POLIO**: (date series completed)			

HEALTHCARE PROVIDER INFORMATION

Provider Name: (print)	**Address:**	
Provider signature:		
Date signed:	**Phone:**	**Fax:**

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

Program Name: _____

Name (Please print):	DOB:

SCREENING FOR TUBERCULOSIS REQUIRED

Staff Member: Please answer the tuberculosis screening questions below and **sign where indicated** (any 'YES' answers require tuberculosis testing, as below):

1. Do you 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. Were you 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. Do you have a history of positive PPD skin test or IGRA blood test?	☐ Yes ☐ No
4. Have you ever had close contact with persons known or suspected to have active TB disease?	☐ Yes ☐ No
5. Have you 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. Are you 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

Staff Signature: _____ Date: _____

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

Instructions: If you answered 'yes' to any of the above screening questions you **must schedule an appointment with your healthcare provider** to have tuberculosis testing. Testing is **REQUIRED** to be performed after 7/1/2024 (QFT or PPD)

QUANTIFERON GOLD (preferred)

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

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