SKIDMORE
COLLEGE

Spring 2024

Dear Summer Staff,

The Skidmore College Office of Special Programs is looking forward to working with you this summer. This letter is to stress the importance and timeliness of completing the following Health Assessment Form.

It is requested that the Health 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.

It is recommended that you provide documentation of vaccination including MMR (measles mumps, rubella) and Hepatitis B. In recent years, there has been an increase in the number of both measles and mumps cases within the United States. Exposure to measles or mumps in absence of vaccination requires either immunization or leaving campus. Hepatitis B series is 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!

SKIDMORE COLLEGE | Office of **Special Programs**

815 NORTH BROADWAY SARATOGA SPRINGS NEW YORK 12866-1632 518-580-5000

SKIDMORE
C O L L E G E

2024 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 2/15/24 New York State Dept of Health issued a health advisory about measles cases in New York state, Pennsylvania, New Jersey and several other states in the country. Working with college students may put you at increased risk for certain communicable diseases, like measles.
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 instruction on the bottom of the page to determine if you need additional 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

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:

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2024 Summer Staff Health Form (Page 2)
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Staff Name: (Last, First)	Preferred Name:	DOB:

RECOMMENDED VACCINES

1. **MEASLES (Rubeola):** One or 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:**

SKIDMORE COLLEGE

2024 Summer Staff Health Form (Page 3)

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Program Name: ____

Name:	DOB:

SCREENING FOR TUBERCULOSIS REQUIRED

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

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

Signature: ____ Date: ___________

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

If you answered 'yes' to any of the above screening questions you 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:**