New Paltz
STATE UNIVERSITY OF NEW YORK
Student Health Service ▪ Division of Student Affairs
1 Hawk Drive ▪ New Paltz, NY 12561-2443 ▪ 845-257-3400 ▪ Fax 845-257-3415
healthservice@newpaltz.edu

Health Report

Name: _____ Date of Birth: _____ Student ID: _____

Students fill in your name, date of birth and student ID.
Complete the following Forms: Health History Personal and Family, New Paltz TB screening and Minor Consent (if you are less than 18 years old) on the New Paltz Patient Portal. https://newpaltz.medicatconnect.com
Will you be you playing varsity sports at New Paltz? □ Yes □ No Which team? □ N/A _____

Now bring this form to your primary care provider for completion.

Significant Medical Problems	Current Medications or treatment
Allergies to medications: □ yes Medicine (s): □ NKDA	
Allergies to Foods □ none □ yes Foods:	
Allergies to Insects □ none □ yes Insects:	
EpiPen prescribed □ yes □ no	

Date of Exam: _____ Height:_____ inches Weight_____ pounds BP: ____/____ P: _____

N-Normal, ABN- Abnormal, NE- Not Examined

	N	ABN	NE		N	ABN	NE	□ Male □ Female	N	ABN	NE
Skin				Lymph nodes				Female: Breasts			
HEENT				Abdomen				Pelvic (if indicated)			
Lungs				Back				Male: Testes			
Heart				Limbs				Inguinal Canals			
Blood vessels				Neurologic				Anus (if indicated male or female)			
Please comment on ABN findings:											

Is this student able to participate in all physical activities including intercollegiate athletics? □ Yes □ No
Required for intercollegiate athletes: **sickle cell trait test** □ Trait present □ Trait absent □ Unknown.

Will you remain involved in this student's care? □ Yes □ No
Is this student able to meet emotional demands of college □ Yes □ No_____

Provider's name Printed:_____

Provider's signature:_____

Office
Stamp

New Paltz
STATE UNIVERSITY OF NEW YORK
Student Health Service ▪ Division of Student Affairs
1 Hawk Drive ▪ New Paltz, NY 12561-2443 ▪ 845-257-3400 ▪ Fax 845-257-3415
healthservice@newpaltz.edu

STUDENT'S HEALTH CARE PROVIDER, ATTACH STUDENT'S VACCINATION RECORD or COMPLETE FORM.

Student's Name:_____ Date of Birth:_____

REQUIRED VACCINATIONS:

MMR vaccine	Date: M/D/Y	Date: M/D/Y
MMR (Measles, Mumps, Rubella) Two doses required (1st dose after first birthday, 2nd dose at least 28 days after 1st dose)		
Or Blood Test showing Immunity to Measles, Mumps, and Rubella. (Documentation of results is required.)		
Meningitis ACWY vaccine	Date: M/D/Y	Date: M/D/Y
Menveo, Menactra, MenQuadfi, Penbraya One dose within 5 years of first day of class		
Or a completed **Meningitis Vaccination Response Form** declining a vaccination.		

RECOMMENDED VACCINATIONS:

Vaccine	Date: M/D/Y	Date: M/D/Y	Date: M/D/Y
Meningitis B			
Hepatitis B			
Hepatitis A			
Varicella			
Td last booster			
Tdap last booster			
Human Papilloma Virus (HPV)			
Polio 3 doses minimum to complete series	☐ Completed	Date:	

TUBERCULOSIS TEST:

Either a TB skin test or blood test is required for all students with a positive response to a TB screening question.
TB skin test ☐: Date: placed_____ M/D/Y Date: Read_____ M/D/Y Result:_____mm Record mm of induration, if none record "0"
TB blood test ☐: Date done: _____ M/D/Y Result: _____ (Copy of lab report is required.)
Chest x-ray required if skin or blood test is positive. Result: ☐ Normal ☐ Abnormal **Submit copy of written CXR report to Student Health Service**

Health Care Provider Signature: _____