Welcome! This is important information regarding your registration. You will not be able to register for classes without following the instructions contained in the Health and Counseling Services section. New York State (NYS) law requires all college students to produce proof of vaccination or immunity to measles (rubeola), mumps, and rubella (German measles). In addition to the MMR requirement, New York State mandates that colleges must provide information to their students on meningococcal meningitis and transmission thereof; the benefits, risks, and effectiveness of immunization; and the availability and cost of the vaccine. It is also required by NYS that response forms be returned to the institution and kept on file.

Students not fulfilling this requirement within 30 days are prohibited from remaining enrolled in classes.

Pratt Institute is concerned about both the health of our students and the high cost of medical care. Information regarding Pratt’s student health insurance and waiver process is available online at www.pratt.edu/health.

If you have a chronic condition, we have some recommendations to help make your career at Pratt successful.

- First, you may wish to consider enrolling in the Pratt Student Health Insurance Program in addition to your current insurance if it does not provide adequate coverage in New York.

- Second, you should let the Health and Counseling Services staff know about your condition in advance. We are available to provide for students’ physical and mental health needs through primary care services and can make referrals to specialists outside this office. In order to best do so, we need accurate and complete health information. Therefore, you will need to have a complete physical exam prior to beginning your studies at Pratt.

- Finally, please make sure that the forms are fully completed and signed by a medical provider. Pratt’s Health and Counseling Services welcomes the opportunity to assist students in maintaining their optimal health status.

We wish you a happy and healthy experience at Pratt. For more information about Health and Counseling Services, visit Pratt’s website at www.pratt.edu/health. Use the contact information below.

Health and Counseling Services
Pratt Institute
215 Willoughby Avenue, Suite 117
Brooklyn, NY 11205
Telephone: 718.399.4542
Fax: 718.399.4544
Email: health@pratt.edu

Please return the Health Evaluation Form, along with the rest of the admissions forms, to the Admissions Office in the pre-addressed envelope provided, by June 15 for fall entrance and by January 1 for spring entrance. Please keep copies of any submitted forms for future reference.
The information listed below is subject to change. Please visit www.pratt.edu/health to check for updates.

STUDENT HEALTH INSURANCE PLAN

Important Information
Pratt Institute requires all registered full-time and part-time students to carry adequate health insurance. Student health insurance is offered by Pratt Institute, and all registered students are automatically charged a student health insurance fee. Half of the annual fee will appear as a line item charge on your fall semester account, and the balance will appear on your spring semester account. Students who are currently insured under family or private medical insurance may waive (opt out of) the Student Health Insurance Plan, thus removing the student health insurance fee from their account. Registered students who are in need of health insurance may enroll in the Student Health Insurance Plan.

Instructions and reminders about the student health insurance waiver/enrollment process will be mailed to new students. Email reminders are sent to all registered students as well. This process must be completed by the end of the add/drop period. Waiving of the student health insurance is done on an annual basis, during the fall semester, unless you are a new incoming student in the spring. You must complete an online waiver during the fall semester for the full academic year if you wish to opt out of the Student Health Insurance Plan. Please note that insurance information submitted for the waiving process is subject to audit to confirm that the policy is current and the coverage is adequate.

We work diligently with Pratt Institute’s Student Health Insurance Plan administrators to offer a medical insurance program specifically designed for Pratt students. Our primary objective has always been to offer a plan that contains substantial benefits at a reasonable cost. The plan has been well received by our students who have indicated that—even in the face of medical inflation—their primary concern is that our plan should maintain a high level of benefits. When compared to other colleges in the area, Pratt’s Student Health Insurance Plan provides one of the highest benefit packages at the lowest cost.

If you have questions about benefits provided by the Student Insurance Plan, please contact our insurance broker, Gallagher Student Health at www.gallagherstudent.com or 1.800.457.5599. For general questions, please contact Pratt Health and Counseling at 718.399.4542 or email at health@pratt.edu.
Health Evaluation Form Fall 2016–Spring 2017

Contact Information

Forms should be received by the Office of Health and Counseling no later than June 15, 2016, for fall entrance or January 1, 2017, for spring entrance.

Please complete this form carefully with your physician, and submit it with your admission documents. The information supplied is part of your health record; it will be held in STRICT CONFIDENCE at the Office of Health and Counseling Services. This will not affect your academic standing at the Institute.

First Name: ___________________________ Last Name: ___________________________ Middle Initial: ___________________________

Date of Birth (mm/dd/yy) ___________________________ Legal Sex: ○ M ○ F

Date of Entrance: ○ Spring ○ Summer ○ Fall Year: ________

Pratt ID Number or Social Security Number

Email Address (Pratt preferred)

Home Address:

City: ___________________________ State: _______ ZIP: ___________________________ Country:

Phone: ___________________________ ○ Home ○ Cell

Emergency Contact (U.S. contact preferred if international student):

Name: ___________________________ Relationship: ___________________________

Address:

City: ___________________________ State: _______ ZIP: ___________________________

Phone: ___________________________ ○ Home ○ Cell

College students under age 18 must have parent/guardian sign here to authorize medical treatment outside of Health and Counseling office:

Emergency Medical Authorization

I, the undersigned parent or legal guardian of ___________________________, do hereby authorize Pratt Institute, on my behalf, to consent to any emergency hospital care or treatment to be rendered to him or her upon the advice of any licensed provider. I agree to be responsible for all necessary charges incurred by any hospitalization or treatment rendered pursuant to this authorization.

Signature: ___________________________ Date: ___________________________

Print Name: ___________________________ Phone Number: ___________________________
Meningococcal Meningitis Response

College students in dormitories are at increased risk for meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis. A U.S. health advisory panel recommends that college students, particularly freshmen living in dorms, learn more about meningococcal meningitis and vaccination.

On July 22, 2003, New York State Public Health Law (NYS PHL) §2167 was passed requiring institutions, including professional schools and universities, to provide information to all students about meningococcal meningitis.

New York State Public Health Law (NYS PHL) §2167 requires that all college and university students enrolled for at least six (6) semester hours or the equivalent per semester, or at least four (4) semester hours per quarter, complete and return the following form.

What Is Meningococcal Meningitis?
Meningitis is rare. But when it strikes, this potentially fatal bacterial disease can lead to swelling of fluid surrounding the brain and spinal column and to severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation, and even death.

Meningococcal meningitis is spread through the air via respiratory secretions or close contact with an infected person. This can include coughing, sneezing, kissing, or sharing items like utensils, cigarettes, and drinking glasses. Symptoms of meningococcal meningitis often resemble the flu and can include high fever, severe headache, stiff neck, rash, nausea, vomiting, lethargy, and confusion.

Certain college students—particularly freshmen who live in dormitories or residence halls—have been found to have an increased risk for meningococcal meningitis. Other students can also consider vaccination to reduce their risk for the disease, although it is not required for health care workers.

Can Meningitis Be Prevented?
Yes. A safe and effective vaccine is available to protect against four of the five most common strains of the disease.

A new version of the vaccine provides long-term protection. As with any vaccine, vaccination against meningitis may not protect 100 percent of all susceptible individuals. You can find more information at www.cdc.gov/vaccines/vpd-vac/mening/default.htm.

Please check one box and sign below:

☐ I have had a meningococcal meningitis immunization within the past 10 years. Date received __________________________ (mm/dd/yy)

OR

☐ I have read the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine.
  I have decided that I will not obtain immunization against meningococcal meningitis disease.

STUDENT’S SIGNATURE REQUIRED

Signature (If under 18, then Parent/Guardian signature): __________________________ Date: __________________________

Print Name: __________________________
Personal Health Information

Student Information  To be completed by the student. Please print.

First Name ___________________________________________ Last Name _________________________________________ Middle Initial ______________________________

Date of Birth (mm/dd/yy) ______________________________ Sex: ☐ M ☐ F

RECOMMENDED VACCINES  Please complete and attach official records, if available.

1. Last Tetanus Diphtheria booster
   Date: __________ / ________ / ________(mm/dd/yy)

2. Completed primary series of Polio Vaccine
   Date: __________ / ________ / ________(mm/dd/yy)

3. Hepatitis A Vaccine
   Date 1: __________ / ________ / ________(mm/dd/yy)
   Date 2: __________ / ________ / ________(mm/dd/yy)

4. Hepatitis B Vaccine
   Date 1: __________ / ________ / ________(mm/dd/yy)
   Date 2: __________ / ________ / ________(mm/dd/yy)
   Date 3: __________ / ________ / ________(mm/dd/yy)

5. Chickenpox (Varicella) Vaccine
   Date 1: __________ / ________ / ________(mm/dd/yy)
   Date 2: __________ / ________ / ________(mm/dd/yy)

6. HPV Vaccine
   Date 1: __________ / ________ / ________(mm/dd/yy)
   Date 2: __________ / ________ / ________(mm/dd/yy)
   Date 3: __________ / ________ / ________(mm/dd/yy)

BRIEF HEALTH HISTORY

1. Do you have allergies?
   ☐ YES.  Please list.
   Medicine: __________________________________________
   Food: __________________________________________
   Environment: ______________________________________

   ☐ NO. Proceed to question 2.

2. Medical Problems (requiring a specialist or prescribed medications or treatments)
   __________________________________________________
   __________________________________________________
   __________________________________________________

3. Surgery History (when and why)
   __________________________________________________
   __________________________________________________
   __________________________________________________

4. Mental Health Issues and Treatment
   __________________________________________________
   __________________________________________________
   __________________________________________________

5. Please list ANY medications you are taking
   __________________________________________________
   __________________________________________________
HEALTH EVALUATION FORM FALL 2016–SPRING 2017

Immunization and Screening
This page must be completed and signed by a medical provider.

Student First Name _______________________________ Last Name _______________________________ Date of Birth (mm/dd/yy) _______________________________

MMR History (NYS requirement) To be completed by a health care provider.

- MMR (measles, mumps, rubella): Given as a combined dose instead of individual immunizations
  - Dose 1: Immunized with live vaccine on or after 1 year of age: ________/______/______(mm/dd/yy)
  - Dose 2: Immunized with live vaccine at least 30 days after first dose: ________/______/______(mm/dd/yy)
  - OR

Live Individual Vaccines
- Measles Dose 1: Immunized with live vaccine on or after 1 year of age: ________/______/______(mm/dd/yy)
- Measles Dose 2: Immunized with live vaccine at least 30 days after first dose: ________/______/______(mm/dd/yy)
- Mumps: Immunized with live vaccine on or after 1 year of age: ________/______/______(mm/dd/yy)
- Rubella: Immunized with live vaccine on or after 1 year of age: ________/______/______(mm/dd/yy)
  - OR

TITER: (blood test) showing positive immunity (Dated laboratory results MUST BE ATTACHED)
- Measles, Mumps, Rubella: ________/______/______(mm/dd/yy)

TB (Tuberculosis) Screening Required
To be completed by a health care provider.

1. Does the student have signs or symptoms of active TB?
   - YES. Proceed with additional evaluation to exclude active TB disease, including tuberculin skin testing, IGRA Blood Test, chest X-ray, and sputum evaluation as indicated.
   - NO. Proceed to question 2.

2. Has the student traveled/lived in a high incidence country?*
   - NO. Stop, no further evaluation at this time.
   - YES. Perform TB skin test OR IGRA blood test OR chest X-ray.

*See for details: www.acha.org/Publications/docs/ACHA_Tuberculosis_Screening_April2014.pdf.

TB Skin Test:
- Date Placed: ________/______/______(mm/dd/yy)
- Date Read: ________/______/______(mm/dd/yy)

Result: ________________x____________ mm; If no induration, write “0.”

Interpretation (based on mm of induration as well as risk factors)
- Positive
- Negative
  - OR

IGRA Results:
- Positive
- Negative
- Indeterminate (please attach)

If either test is positive or there is a history of a past positive PPD, a chest X-ray is required.

Result:
- Normal
- Abnormal

Date of X-ray: ________/______/______(mm/dd/yy)

Dates of treatment, including medication dose and frequency:

MANDATORY MEDICAL PROVIDER INFORMATION
Name: _______________________________ MD/NP/PA/RN Phone Number: _______________________________

Address: _______________________________

SIGNATURE OF MEDICAL PROVIDER: _______________________________ DATE: _______________________________

STUDENT NAME _______________________________

PAGE 4 OF 5
Physical Exam and Clearance
To be completed by medical provider.

Student Name (First, Last): ________________________________ Sex: ☐ M ☐ F
Date of Birth (mm/dd/yy): ________________________________ Date of Exam: ________________________________
Height: ______ ft. ______ in. Weight: ______ lb. Pulse: _______/min Blood Pressure: ________________________________
Vision: (L) (R) (Both) Corrected: ☐ Yes ☐ No
Hearing: ________________________________
Allergies: ________________________________
Current Medications: ________________________________

Please comment on the following:
Skin: ____________________________________________ Genitourinary: ________________________________
PMH: ____________________________________________ Pelvic: ________________________________
HEENT: _________________________________________ Muscular/Skeletal: ________________________________
Lungs/Chest: ____________________________________ Neurological: ________________________________
Breasts: _________________________________________ Endocrine: ________________________________
Heart/Vascular: ________________________________ Psychiatric: ________________________________
Abdomen: ______________________________________

Diagnosis/Treatment/Recommendation: ________________________________________________________________

As requested by Pratt Institute, I certify that I have, on this date, examined this student. On the basis of this examination and the student’s medical history as furnished to me:

☑ The student is cleared to participate in supervised college activities including athletics.

☐ The student is cleared WITH RESTRICTIONS to participate in supervised college activities including athletics.

Restriction(s): ________________________________________________________________________________

☐ The student is NOT cleared to participate in supervised college activities including athletics.

Reason: ______________________________________________________________________________________

If conditions arise after the student is cleared for participation, the provider may rescind the clearance until the problem is resolved.

EXAMINER’S SIGNATURE REQUIRED
Examiner’s Name (Print/Stamp): ________________________________________________________________
Address: ________________________________________________________________
Phone Number: ________________________________________________________________
Signature/Title: ________________________________ (MD/NP/PA) Date: ________________________________

STUDENT NAME ________________________________ PAGE 5 OF 5