**PREADMISSION PHYSICAL EXAM AND IMMUNIZATION FORM**

- *Please complete pages 1, 2, 3 & 4 yourself.*
- *Your Health Care Provider should complete pages 5 & 6.*

### NAME AND ADDRESS PLEASE PRINT

<table>
<thead>
<tr>
<th>Last Name, First Name, MI</th>
<th>College ID # (M number)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Street Address/PO Box/Apt.#</th>
<th>City</th>
<th>State</th>
<th>ZIP</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Telephone</th>
<th>Date of Birth</th>
<th>Age</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ Male □ Female □ Other</td>
</tr>
</tbody>
</table>

### EMERGENCY CONTACTS (PERSONS TO BE CONTACTED IN CASE OF EMERGENCY) Please list two contacts

1. Name | Relationship | Home Phone |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>Business Phone</td>
<td></td>
</tr>
</tbody>
</table>

2. Name | Relationship | Home Phone |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>Business Phone</td>
<td></td>
</tr>
</tbody>
</table>

### PRIMARY CARE PHYSICIAN

<table>
<thead>
<tr>
<th>Phone</th>
<th>Address</th>
<th>Fax</th>
</tr>
</thead>
</table>

**HEALTH INSURANCE:** PLEASE CONTACT YOUR HEALTH INSURANCE CARRIER TO BE SURE YOU KNOW YOUR MEDICAL COVERAGE FOR SERVICES IN THE MORRISVILLE AREA. It would be beneficial for students to have their own card or a copy in their possession while at college.
**PERSONAL MEDICAL HISTORY**

<table>
<thead>
<tr>
<th>HAVE YOU HAD?</th>
<th>Yes</th>
<th></th>
<th>Yes</th>
<th></th>
<th>Yes</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles</td>
<td>Head Injury w/ unconsciousness</td>
<td></td>
<td>Hepatitis</td>
<td></td>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>German Measles</td>
<td>SURGERY</td>
<td></td>
<td>Stomach or Intestinal Trouble</td>
<td></td>
<td>Kidney Disease</td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td>Appendectomy</td>
<td></td>
<td>Gallbladder</td>
<td></td>
<td>Heart Disease</td>
<td></td>
</tr>
<tr>
<td>Chicken Pox</td>
<td>Tonsillectomy</td>
<td></td>
<td>Recurrent Diarrhea</td>
<td></td>
<td>High blood pressure</td>
<td></td>
</tr>
<tr>
<td>Malaria</td>
<td>Hernia Repair</td>
<td></td>
<td>Hernia</td>
<td></td>
<td>Cancer</td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>Other (describe below in comments)</td>
<td></td>
<td>Acne (on medication)</td>
<td></td>
<td>Epilepsy/Seizures</td>
<td></td>
</tr>
<tr>
<td>Mononucleosis</td>
<td>Seizures</td>
<td></td>
<td>Urine Infection</td>
<td></td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Gum/Tooth Trouble</td>
<td>Weakness/Paralysis</td>
<td></td>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye Trouble</td>
<td>Shortness of Breath</td>
<td></td>
<td>Disease/Injury of Joints</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ear Infections</td>
<td>Seasonal Allergies</td>
<td></td>
<td>Back Problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Throat Infections</td>
<td>Asthma</td>
<td></td>
<td>Tumor/Cancer (explain below)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insomnia</td>
<td>Palpitations (Heart)</td>
<td></td>
<td>Recent Weight Gain or Loss</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety/Depression</td>
<td>High Blood Pressure</td>
<td></td>
<td>FEMALES ONLY:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Painting Spells</td>
<td>Heart Murmur</td>
<td></td>
<td>Irregular Periods</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migraines</td>
<td>Rheumatic Fever</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**COMMENTS:** NONE OF THE ABOVE APPLY

---

**ATTENTION:** FOR STUDENTS **UNDER EIGHTEEN (18)**

**CONSENT TO TREAT**

In order to provide routine and/or emergent care that may be necessary for students and at the same time to protect the providers and institutions involved, please complete and sign below:

I, ____________________________________________ do hereby authorize the medical and counseling staff of SUNY Morrisville’s Student Health Center to provide routine care to my son/daughter. This care may include treatment for common illnesses and injuries, physical examinations for participation in sports or clinical rotations, ordering of laboratory tests, prescribing/dispensing of medications, or an initial counseling consultation if initiated by the student. I also give permission to local emergency room departments and their physicians, to provide appropriate medical, psychiatric, and surgical treatment, including anesthetics, as medically indicated in case of emergency for my son/daughter. Administration of a vaccine to a minor requires specific consent. By placing your initials in the box below you are authorizing consent to administer the injection(s) to your son/daughter:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza Vaccine</td>
<td>Tuberculosis testing</td>
</tr>
</tbody>
</table>

---

PRINTED FULL NAME OF STUDENT ___________________________ STUDENT’S DATE OF BIRTH _________

PARENT/GUARDIAN ___________________________ SIGNATURE ___________________________ DATE __________
New York State Public Health Law 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 to SUNY Morrisville Matthias Student Health Center with your admission Health Forms.

Check one box and sign below:

I have (for students under the age of 18: My child has):

☐ had meningococcal immunization within the past 5 years. The vaccine record is attached.

[Note: The Advisory Committee on Immunization Practices recommends that all first-year college students up to age 21 years should have at least 1 dose of Meningococcal ACWY vaccine not more than 5 years before enrollment, preferably on or after their 16th birthday, and that young adults aged 16 through 23 years may choose to receive the Meningococcal B vaccine series. College and university students should discuss the Meningococcal B vaccine with a healthcare provider.]

If refusing the meningococcal vaccine:

☐ I have read, or had explained to me, the information regarding meningococcal disease. I understand the risks of not receiving the vaccine. I have decided that I (my child) will not obtain immunization against meningococcal disease.

__________________________________________  _____________________________
Student’s Name (please print)                  Date of Birth

__________________________________________
Student’s Endorsement  _______________________
(If student is under the age of 18, Parent/Guardian’s signature)  Date
TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE

Student Name: ___________________________ Date of Birth: ____________

1. Have you ever had close contact with persons known or suspected to have active TB disease? □ Yes □ No

2. Were you born in or lived in one of the countries or territories listed below that have a high incidence of active TB disease? (If yes, please CIRCLE the country, below) □ Yes □ No

Afghanistan 
Algeria 
Angola 
Anguilla 
Argentina 
Armenia 
Azerbaijan 
Bangladesh 
Belarus 
Belize 
Benin 
Bhutan 
Bolivia (Plurinational State of) 
Bosnia and Herzegovina 
Botswana 
Brazil 
Brunei Darussalam 
Bulgaria 
Burkina Faso 
Burundi 
Cabo Verde 
Cambodia 
Cameroon 
Central African Republic 
Chad 
China 
China, Hong Kong SAR 
China, Macao SAR 
Colombia 
Comoros 
Congo 
Côte d'Ivoire 
Democratic People's Republic of Korea 
Democratic Republic of the Congo 
Djibouti 
Dominican Republic 
Ecuador 
El Salvador 
Equatorial Guinea 
Eritrea 
Ethiopia 
Fiji 
Gabon 
Gambia 
Georgia 
Ghana 
Greenland 
Guam 
Guatemala 
Guinea 
Guinea-Bissau 
Guyana 
Haiti 
Honduras 
India 
Indonesia 
Ireland 
Iraq 
Kazakhstan 
Kenya 
Kiribati 
Kuwait 
Kyrgyzstan 
Lao People's Democratic Republic 
Latvia 
Lesotho 
Liberia 
Libya 
Lithuania 
Madagascar 
Malawi 
Malaysia 
Maldives 
Mali 
Marshall Islands 
Mauritania 
Mauritius 
Mexico 
Micronesia (Federated States of) 
Mongolia 
Montenegro 
Morocco 
Mozambique 
Myanmar 
Namibia 
Nauru 
Nepal 
New Caledonia 
Nicaragua 
Niger 
Nigeria 
Northern Mariana Islands 
Pakistan 
Palau 
Panama 
Papua New Guinea 
Paraguay 
Persia 
Peru 
Philippines 
Portugal 
Qatar 
Quatar 
Republic of Korea 
Ukraine 
Republic of Moldova 
Romania 
Russian Federation 
Rwanda 
Sao Tome and Principe 
Senegal 
Serbia 
Sierra Leone 
Singapore 
Solomon Islands 
Somalia 
South Africa 
South Sudan 
Sri Lanka 
Suriname 
Swaziland 
Syrian Arab Republic 
Tajikistan 
Tanzania (United Republic of) 
Thailand 
Timor-Leste 
Togo 
Tunisia 
Turkmenistan 
Tuvalu 
Uganda 
Ukraine 
Uruguay 
Uzbekistan 
Vanuatu 
Venezuela (Bolivarian Republic of) 
Viet Nam 
Yemen 
Zambia 
Zimbabwe


3. Have you had frequent or prolonged visits to one or more of the countries or territories listed above with a high prevalence of TB disease? (If yes, CHECK the countries or territories, above) □ Yes □ No

- If the answer is YES to any of the above questions, you are required to receive TB testing (within 6 months) prior to your arrival on campus.

- If the answer to all of the above questions is NO, no further testing or further action is required.

Student Signature (Parent/Guardian if under age 18) ___________________________ Date ____________

Rev. 2-28-2023
**THIS SECTION IS TO BE COMPLETED BY HEALTH CARE PROVIDER**

**PHYSICAL EXAMINATION**

Ht. _____ Wt. _____ BP _____ Pulse_____

**Build:** □ Slender □ Med. □ Heavy □ Obese

---

### CLINICAL EXAMINATION

<table>
<thead>
<tr>
<th>Item</th>
<th>Normal</th>
<th>Abnormal</th>
<th>If abnormalities are noted, please describe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neck</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HEENT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs, chest and breasts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart (include any murmur/defect)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen (include hernia)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitalia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal/Extremities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurologic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Lab tests at discretion of physician (please enclose copy of any labs ordered)

**Is this student able to participate in all sports/physical activity?** □ Yes □ No

If “NO,” what activities to be eliminated?

**Do you recommend further investigation or treatment?** □ No □ Yes (Please explain “yes”)

---

**ALLERGY TO:** (Please circle Yes or No)

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insect bites/bee stings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foods</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

Does patient carry an Epi-pen? □ Yes □ No

**CURRENT MEDICATIONS:** Please list any prescription, over the counter, herbal medications, birth control pills:

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>Reason for Taking</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Name of examining Physician/NP/PA**

<table>
<thead>
<tr>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Date of Exam**

**Signature**

<table>
<thead>
<tr>
<th>Area code and phone #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>
### REQUIRED IMMUNIZATIONS

Students with incomplete immunization records will have a MEDICAL HOLD placed on their account and can face dismissal from SUNY Morrisville.

#### MMR

<table>
<thead>
<tr>
<th>First Dose</th>
<th>Second Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles, Mumps, Rubella</td>
<td>Measles, Mumps, Rubella</td>
</tr>
<tr>
<td>MM/DD/YY</td>
<td>MM/DD/YY</td>
</tr>
</tbody>
</table>

If born after 1956, two doses of live virus measles vaccine, or MMR, the first dose at 12 months of age or later and the second dose at least one month later. Persons born before 1957 are exempt due to natural immunity from the disease.

OR

2 doses Measles 1st 2nd 1 dose Mumps 1 dose Rubella

MM/DD/YY MM/DD/YY MM/DD/YY MM/DD/YY

Serologic evidence (blood work) of immunity to each. **Lab work must be submitted.**

#### MENINGOCOCCAL VACCINE (ACWY)

<table>
<thead>
<tr>
<th>MM/DD/YY</th>
<th>MM/DD/YY</th>
</tr>
</thead>
</table>

#### MENINGOCOCCAL B VACCINE

<table>
<thead>
<tr>
<th>MM/DD/YY</th>
<th>MM/DD/YY</th>
</tr>
</thead>
</table>

#### TUBERCULOSIS TESTING:

REQUIRED FOR THOSE AT HIGH-RISK (based on tuberculosis screening questionnaire).

Check here if student at low risk and tuberculosis testing not completed □

PPD (Mantoux) within 6 months of admission to college

Date Administered  Date Interpreted  Result

If currently positive or prior history of positive PPD, chest x-ray report and/or Quantiferon Gold or T-spot testing required (in **ENGLISH** and done within 6 months of admission), with date and result must be submitted.

#### COVID-19

#1 #2 #3 *(Please circle) Johnson & Johnson  Moderna  Pfizer

#### TETANUS

Within 10 years of admission to college

*(Please circle) Td  Tdap

month/day/year

#### HEPATITIS B

#1 #2 #3

#### VARICELLA

_____ history or chicken-pox  Date: __________

OR  #1 #2 *(Required if given at age 13 or older)

OR  Titer (include lab report) ____________

**SIGNATURE/MEDICAL PROFESSIONAL CERTIFYING ABOVE IMMUNIZATION RECORD**

Please return completed forms to:

**SUNY Morrisville**
Matthias Student Health Center
PO Box 901
Morrisville, NY 13408

Phone (315) 684-6078  Fax (315) 684-6493