



SUNY MORRISVILLE

PREADMISSION PHYSICAL EXAM AND IMMUNIZATION FORM

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

NAME AND ADDRESS PLEASE PRINT		DATE	
Last Name, First Name, MI		College ID # (M number)	
Street Address/PO Box/Apt.#		City	State ZIP
Telephone	Date of Birth	Age	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

EMERGENCY CONTACTS (PERSONS TO BE CONTACTED IN CASE OF EMERGENCY) Please list two contacts		
1. Name	Relationship	Home Phone
Address		Business Phone
2. Name	Relationship	Home Phone
Address		Business Phone

PRIMARY CARE PHYSICIAN	Phone
Address	Fax

HEALTH INSURANCE: All students taking 12 credit hours or more are required by federal law to be covered by health insurance. **PLEASE CONTACT YOUR HEALTH INSURANCE CARRIER TO BE SURE YOU ARE COVERED FOR ALL MEDICAL SERVICES WITHIN 50 MILES OF MORRISVILLE STATE COLLEGE.** Students will be charged for the Student Health Insurance unless a waiver form is submitted in [Web for Students](#). You will be asked to upload a picture of your insurance card during the waiver process. It would be beneficial for you to have your own card or a copy in your possession while at college.

STUDENT LAST NAME

FIRST

DOB

PLEASE COMPLETE THIS SECTION BEFORE GOING TO YOUR HEALTH CARE PROVIDER FOR EXAMINATION (please print).

PERSONAL MEDICAL HISTORY

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

COMMENTS: NONE OF THE ABOVE APPLY

Four horizontal lines for additional comments.

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
PARENT/GUARDIAN PLEASE PRINT NAME

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:

Table with 2 columns: Influenza Vaccine, Tuberculosis testing

PRINTED FULL NAME OF STUDENT

STUDENT'S DATE OF BIRTH

PARENT/GUARDIAN SIGNATURE

DATE

MENINGOCOCCAL VACCINATION RESPONSE **FORM**

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 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 have 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 Signature (Parent/Guardian if under age 18)

Date

STUDENT LAST NAME

FIRST

DOB

THIS SECTION IS TO BE COMPLETED BY HEALTH CARE PROVIDER

PHYSICAL EXAMINATION

Ht. _____ Wt. _____ BP _____ Pulse _____ Build: Slender Med. Heavy Obese

CLINICAL EXAMINATION			
Check each item in proper column; Enter NE if not evaluated.	Normal	Abnormal	If abnormalities are noted, please describe
Neck			
HEENT			
Lungs, chest and breasts			
Heart (include any murmur/defect)			
Abdomen (include hernia)			
Genitalia			
Musculoskeletal/Extremities			
Skin			
Neurologic			
Psychiatric			

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 are to be eliminated?** _____

Do you recommend further investigation or treatment? No Yes (Please explain "yes")

ALLERGY TO: (Please circle Yes or No)

Medication No Yes (Pleaselist) _____

Insect bites/bee stings No Yes _____

Foods No Yes (Please list) _____

Other Yes Please explain _____

Does patient carry an Epi-pen? Yes No

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

Name	Dose	Reason for Taking

Name of examining Physician/NP/PA		Date of Exam	
Street	City	State	Zip code
Signature		Area code and phone #	

STUDENT LAST NAME

FIRST

DOB

THIS SECTION IS TO BE COMPLETED BY HEALTH CARE PROVIDER

REQUIRED IMMUNIZATIONS
Students with incomplete immunization records will have HOLD placed on their account and can face dismissal from SUNY Morrisville

MMR	First Dose	Second Dose
<i>Measles, Mumps, Rubella</i>	_____	_____
	MM/DD/YY	MM/DD/YY

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

OR

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

MENINGOCOCCAL VACCINE (ACWY)	
_____	_____
MM/DD/YY	MM/DD/YY

MENINGOCOCCAL B VACCINE	
_____	_____
MM/DD/YY	MM/DD/YY

TUBERCULOSIS TESTING: REQUIRED FOR INTERNATIONAL STUDENTS AND THOSE AT HIGH-RISK.

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

PPD (Mantoux) within 6 months of admission to college _____ mm induration
Date Administered Date Interpreted Result

If currently positive or prior history of positive PPD, chest x-ray report (in ENGLISH and done within 6 months of admission), with date and result must be submitted with physical.

TETANUS Within 10 years of admission to college _____ (Please circle) Td Tdap
month/day/yr

HEPATITIS B #1 _____ #2 _____ #3 _____

VARICELLA _____ history of 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