EST. 1908

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<br>□ Male □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**

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

**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
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:

| | | | |
|---|---|---|---|
| | 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** |
|---|---|---|
| *Measles,Mumps,Rubella* | _____ 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_____ MM/DD/YY 2nd _____ MM/DD/YY 1 dose **Mumps** _____ MM/DD/YY 1 dose **Rubella** _____ 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 _____ Date Administered _____ Date Interpreted _____ Result mm induration

***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** **W**ithin 10 years of admission to college _____ month/day/yr (*Please circle*) Td Tdap

**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

Revised 8/1/18