

Medical History, Immunization Record, and Physical Examination

Included in this packet you will find the required health forms to be completed by you and your physician. Please have this completed and sent back to Health Services by **June 30** if you are beginning in the fall semester and **Dec. 31** if you are beginning in the spring semester. If you are accepted after this date, please return the form prior to the first day of classes. **Failure to return a completed health form may result in denial of pre-registration, withholding of transcripts, inability to receive non-emergent health care, and possible class suspension.**

Return to:

**Health Services
TA Parish Hall
Alfred State
10 Upper College Drive
Alfred, New York 14802**

(607) 587-4200

FAX: (607) 587-4203

E-mail: healthservices@alfredstate.edu

Monday-Friday: 8 a.m. - 4:30 p.m.

www.alfredstate.edu/student-services/health-services

NYS Public Health Laws #2165 and 2167 require specific immunizations as detailed on the physical exam form and on the meningitis information response form on the last page. Students who do not comply will be suspended as dictated by the wording of the law.

Health Services

State University of New York College of Technology
Alfred, New York 14802
(607) 587-4200 • Fax (607) 587-4203
www.alfredstate.edu/student-services/health-services

I will be attending classes on the
 Alfred Campus
 Wellsville Campus

Health History

For the Student: You will not be permitted to register for ensuing semesters or receive health care until this **completed form packet is received by Health Services.**

You and your parents complete this page; parts A, B, and C before seeing your physician, who completes the Health Evaluation on the following page.
All information is held strictly confidential by Health Services and will not influence your standing at the College.

A. _____, _____, _____, _____/_____/_____, _____
Last Name First Middle Date of Birth Age

Home Address (Street & No.) City/Town State Zip Code

Student's Cell Phone: _____ Student's Home Phone: _____

Social Security Number: _____ - _____ - _____ Have you ever attended Alfred State College? Yes No

In case of emergency, Health Services will notify:
_____, _____, Business Phone: (_____) _____
(Relationship) Area Code

Home Phone: (_____) _____ Religious Preference (Optional) _____
Area Code

B.

| | | | | | | | |
|-----------------------------|------------------------------|---|-----------------------------|------------------------------|-----------------------------|-----------------------------|------------------------------|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | 1. Do you require any special housing arrangements or medical supervision? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | 2. Has your physical activity been restricted during the last five years? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | 3. Are you currently taking any medication regularly? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | 4. Have you ever received treatment or counseling for a nervous condition or emotional problem? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | 5. Have you any questions you would like to discuss with a member of Health Services? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | 6. Do you smoke? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | 7. Do you use alcohol? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | | 8. Have you ever had: | | | | | |
| | | Allergy to Any Medications | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Yellow Jaundice (Hepatitis) | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | | Seizures (convulsions) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Kidney Trouble | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | | Hayfever or Asthma | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Mononucleosis | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | | Rheumatic Fever | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Chickenpox or Varicella | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | | Heart Murmur or Condition | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Eating Disorder | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | | High Blood Pressure | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Alcohol or Other Drug Abuse | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | | Rupture (Hernia) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Surgery | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | | Joint Disease or Injury | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Head Injury | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | | Diabetes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | | |

Use the blank space below to give details of all "Yes" responses.

Student Signature _____ Date _____

C. Health Insurance: It is important that the student be covered by some form of health insurance or by the College's optional insurance. This is to confirm that the student is covered during the academic year by the following health insurance policy. (Include a photocopy, front and back, of insurance card.)

1. Name of policy holder: _____ 2. Policy # _____
(as written on Identification Card)

3. Name of Insurance Company: _____ 4. Group # _____ 5. Sequence # _____

Address of Insurance Company: _____

I have purchased the College optional insurance.

| | |
|---|---|
| <p>To be completed by Health Science Students and/or Intercollegiate Athletes: (Nursing/Veterinary Technology) In order to maintain the health and safety of their clients and meet state health laws, agencies used for clinical experience require selected information from the student's health record.</p> <p>In order for intercollegiate athletes to meet eligibility requirements and provide athletics training services in conjunction with your health care, athletes must sign this consent for release of medical information from the Health Services to the Athletics Department.</p> <p>Permission is hereby granted SUNY Alfred to release required information to above said agencies.</p> <p>Student Signature _____ Date _____</p> | <p>Check all that apply:</p> <p><input type="checkbox"/> Athlete</p> <p><input type="checkbox"/> Nursing student</p> <p><input type="checkbox"/> Veterinary Technology student</p> |
|---|---|

For the physician: The student will not be permitted to register for ensuing semesters until this form is received by Health Services at the above address. All information you provide will be held strictly confidential and will not influence the student's academic standing at the College. **Note: All immunizations and meningitis response form must be completed before form can be accepted. Measles, mumps, and rubella immunizations not required for students born before 1/1/57 unless in nursing program. Physical exam must have been completed within the last year.**

Health Evaluation

Date of exam: _____ DOB: _____
 Name: _____ Sex: _____
 Height: _____ Weight: _____
 B/P: _____ Pulse: _____
 Allergies: _____
 Medications: _____
 Current Diagnosis: _____

Mantoux (PPD) Date Placed: _____ Date Read: _____
 Result in MM _____ (must be done in last 6 months) Tine Test not acceptable
 Chest x-ray if positive Date: _____ Result: _____
 Was medication initiated for positive mantoux? _____
 Vision: Snellen No Lenses Lenses Forgot Lenses
 R: 20/ _____ L: 20/ _____

Immunizations Required by Public Health Law 2165:
 Must be given after Jan. 1, 1969, on or after the first birthday.

Measles (Rubeola) 2 doses:

1st ____/____/____ MMR Yes No
 Mo Day Yr

2nd ____/____/____ MMR Yes No
 Mo Day Yr

Rubella ____/____/____ **Mumps** ____/____/____
 Mo Day Yr Mo Day Yr

A titer proving immunity for each of the above is an acceptable alternative to receiving the immunizations. A copy of the results is required. Please attach to this form.

Tdap Date: _____ **Td** Date: _____ (within last seven years)

Laboratory Data:

Urinalysis: SG _____ Protein _____ Sugar _____

Hepatitis B Vaccine given as follows:

Dose #1 _____ Dose #2 _____ Dose #3 _____

Menvo Vaccine Date: _____
Menomune Vaccine Date: _____
Menactra Vaccine Date: _____
Please provide documentation of immunization

} Student must sign form on page 4

Varicella Vaccine Date: _____

Required for Veterinary Technology students, Rabies Series given as follows:

Dose #1 _____ Dose #2 _____ Dose #3 _____

Contact your department faculty for further details.

| Physical Exam | Normal | Abnormal | Explanation |
|-------------------------|--------|----------|-------------|
| 1. Eyes | | | |
| 2. Ears, Nose, Throat | | | |
| 3. Hearing | | | |
| 4. Mouth/Teeth | | | |
| 5. Cardiovascular | | | |
| 6. Chest/Lungs | | | |
| 7. Abdomen | | | |
| 8. Genitourinary | | | |
| 9. Musculoskeletal | | | |
| 10. Metabolic Endocrine | | | |
| 11. Neuropsych | | | |
| 12. Skin | | | |
| 13. Lymphatic | | | |

Please comment if answering yes to any of the following questions:

Are there any restrictions of physical activity indicated by your exam? ___Yes ___No

Please detail Yes response. _____

Is the student now under treatment for any medical or emotional problem? ___Yes ___No

Please detail Yes response. _____

Do you have any recommendations regarding the care of this student? ___Yes ___No

Please detail Yes response. _____

I have examined the above-named student and it is my professional opinion that the student is physically and psychologically able, except as noted above, to undertake college studies.

 Signature MD/NP/PA Examining Practitioner's Name (please print) Phone Number – include area code Date

 Address – Street and Number City/Town State Zip Code

Meningitis Information Response Form

NYS 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, receive information on meningitis, the meningitis vaccine (see page 5), and **complete the following:**

Check one box and sign below:

I have:

had the meningococcal meningitis immunization within the past 10 years.
Date immunized _____ Menomune or Menactra or Menvo
* Please provide documentation of Meningitis Vaccine

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

Please print name: _____

Student's signature: _____ Date _____

Parent's/Guardian's signature (only if student is under 18) _____ Date _____

Please note that according to NYS Public Health Law, no institution shall permit any student to attend the institution in excess of 30 days without complying with this law.

For Parents/Guardians of applicants *under 18 years of age:*

In order to provide health care quickly and efficiently for your student, it is required that you sign and **have notarized** the consent for treatment. For your information, if your student should require emergency treatment at the local hospital, that facility will notify you and request further consent.

I, _____, pursuant to the authority vested in me as Parent Guardian
Parent or Guardian Name

of _____ do hereby authorize the medical staff of Alfred State College
Student's Full Name

to provide medical treatment for any visits to the Health Services made by my son/daughter. This also authorizes the College physician to become the attending physician for the student in case of hospitalization.

Notary Public
(with seal)

Signature of Parent or Guardian

Subscribed before me this _____ day

of _____
Month Year

Signature of Notary

INFORMATION ABOUT MENINGOCOCCAL MENINGITIS

The State University of New York wants to inform you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis, and a New York State law. On July 22, 2003, Governor Pataki signed New York State Public Health Law (NYS PHL) §2167 requiring institutions, including colleges and universities, to distribute information about meningococcal disease and vaccination to all students meeting the enrollment criteria, whether they live on or off campus. This law became effective Aug. 15, 2003.

Colleges in New York State are required to maintain a record of the following for each student:

- A response to receipt of meningococcal disease and vaccine information signed by the student or student's parent or guardian. This must include information on the availability and cost of meningococcal meningitis vaccine (Menomune™); AND EITHER
- A record of meningococcal meningitis immunization within the past 10 years; OR
- An acknowledgement of meningococcal disease risks and refusal of meningococcal meningitis immunization signed by the student or student's parent or guardian.

Meningitis is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. If not treated early, meningitis can lead to swelling of the fluid surrounding the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation, and even death.

Cases of meningitis among teens and young adults 15 to 24 years of age (the age of most college students) have more than doubled since 1991. The disease strikes about 3,000 Americans each year and claims about 300 lives. Between 100 and 125 meningitis cases occur on college campuses and as many as 15 students will die from the disease.

A vaccine is available that protects against four types of the bacteria that cause meningitis cases among college students.

If you wish to receive the meningococcal meningitis vaccine (Menomune™), it is available either through your private health care provider, your county Department of Health, or Express Care at St. James Mercy Hospital in Hornell. The cost of the vaccine usually ranges from \$65 to \$97.

Please make sure you complete and return the Meningococcal Meningitis Response Form within 30 days of the beginning of the student's first semester. Please note that according to NYS Public Health Law, no institution shall permit any student to attend the institution in excess of 30 days without complying with this law.

To learn more about meningitis and the vaccine, consult with your (child's) physician, or contact the campus health service. You can also find information about the disease at the New York State Department of Health Web site: WWW.HEALTH.STATE.NY.US, Web site of the Centers For Disease Control and Prevention (CDC): WWW.CDC.GOV/NCIDOD/DBMD/DISEASEINFOR, and the American College Health Association (ACHA) Web site: WWW.ACHA.ORG.

Mental Health Information

Optional but appreciated

Students may request that information regarding their mental health be shared with Counseling Services. Please complete this authorization form and the appropriate information will be forwarded.

Counseling Services at Alfred State College is available to assist students with any emotional and social difficulties that may arise at college and to provide support for pre-existing mental health issues. It is the responsibility of the student to contact our office if he/she wishes to receive mental health services. Please fill out this form as fully as possible. All information will be held in strictest confidence and no one will contact you. If questions do not apply, leave them blank.

I give permission to share this information with Counseling Services.

Personal Information

1) Name: _____ 2) Today's date: _____ 3) Age: _____
4) Gender: M F 5) Ethnicity: _____ 6) Marital status: _____

Treatment History

7) Are you currently receiving counseling services? Yes No

If yes, where: _____

Please briefly describe reason(s) for treatment: _____

8) Have you ever received counseling in the past? Yes No

If yes, where (please list ALL previous therapists): _____

Please briefly describe reason(s) for treatment: _____

9) Have you ever been hospitalized for mental health problems? Yes No

| If yes... | Where | When | What led to your hospitalization |
|-----------|-------|-------|----------------------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

10) Please list any known mental health diagnoses that you have: _____

11) Please list any current medications, and also any medications you have taken in the past year, for mental health reasons:

| Type of medication: | Reason taken: | How long have you taken: |
|---------------------|---------------|--------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |