EST. 1908

SUNY MORRISVILLE

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*			DATE
Last Name, First Name, MI			College ID # (M number)
Street Address/PO Box/Apt.#	City	State	ZIP
Telephone	Date of Birth	Age	Gender ☐ 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 KNOW YOUR MEDICAL COVERAGE FOR SERVICES IN THE MORRISVILLE AREA.** 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 complete and return the following form to SUNY Morrisville Matthias Student Health Center.

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

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
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
Peru
Philippines
Portugal
Qatar
Republic of Korea
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
Sudan
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

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2015. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to http://www.who.int/tb/country/en/.

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

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 a MEDICAL 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_____ 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.**

MENINGOCOCCAL VACCINE (ACWY)

_____ _____

MM/DD/YY MM/DD/YY

MENINGOCOCCAL B VACCINE

_____ _____

MM/DD/YY MM/DD/YY

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_____mm induration

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_____ Manufacturer *(Please circle)* Johnson & Johnson Moderna Pfizer

TETANUS **W**ithin 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

Revised 3/18/2021