

Student Health History, Immunization and Physical Exam Form

Davis Health Center
Miller Campus Center 004
34 Cornell Drive, Canton NY, 13617
Phone: 315-386-7333 Fax: 315-386-7932
Email: healthcenter@canton.edu

DUE DATES: Fall Semester **AUGUST 1ST** Spring Semester **JANUARY 1ST**

*This Form includes the New York State
Mandatory College Requirements
All information is confidential*

ATHLETES: DO NOT USE THIS FORM.

Athletes must use the Athletic Pre-Participation Physical Form found on the Athletic or Health Center's web page.

NOTE: If you are taking ALL ONLINE classes and NOT LIVING ON CAMPUS, you are not required to complete this form.

ALL FIELDS ON THIS FORM WITH AN ASTERISK (*) ARE REQUIRED AND NEED TO BE COMPLETED ENTIRELY.

***Student Information**

Print Name (First, Middle Initial, Last): _____ Student ID #: _____

Preferred Name: _____ Preferred Pronouns: _____

Date of Birth: _____ Phone Number (Home): (____) _____ Cell: (____) _____

Home Address: _____
Street
City
State
Zip

Email Address: _____
SUNY Canton email
Personal Email

Entering Term: Fall Spring Year: _____ Program/Major Entering: _____

***Emergency Contact Information**

Print Name (First, Last): _____ Relationship: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Current Health Care Provider Information

Name & Title of Provider: _____ Phone: (____) _____

Address: _____
Clinic/Facility

Street, City, State, Zip

***Please continue this form and complete Parts I – III
(Immunizations, Personal Health History, and Physical Exam)***

Davis Health Center Office Use Only:

Scanned by: _____ Reviewed by: _____ Received Date: _____

Immunizations Input into EHR by: _____ Health Hx Input into EHR by: _____

Student Name: _____

DOB: _____

PART I - IMMUNIZATION/MENINGITIS REQUIREMENTS:

NYS PHL Section 2165 requires students attending post-secondary institutions who were born on or after January 1, 1957 and registered for 6 or more credit hours to demonstrate proof of immunity against measles, mumps, and rubella.

A COPY OF AN OFFICIAL IMMUNIZATION RECORD (I.E. HIGH SCHOOL RECORD) CAN BE ATTACHED.

● Required for ALL students:

● **MMR** (2 doses, First one no more than 4 days before first birthday and at least 28 days apart)

1st _____/_____/_____
Mo Day Yr 2nd _____/_____/_____
Mo Day Yr

OR:

○ **MEASLES** 1st _____/_____/_____
Mo Day Yr 2nd _____/_____/_____
Mo Day Yr

○ **RUBELLA** _____/_____/_____
Mo Day Yr **MUMPS** _____/_____/_____
Mo Day Yr

● **MENINGITIS** *within the past 5 years* (Circle one):
Menomune, Menactra, or Menveo Date: _____

OR:

○ **Completed Meningitis Response Form** (see below)

★ Required for:
Physical Therapy Assistant, Early Childhood, Health & Fitness Promotion, and Nursing students only

◆ Recommended for ALL students:

★ **◆ TETANUS/DIPHTHERIA/PERTUSSIS** (circle one):

Tdap, Boostrix, Adacel or Td (if past hx of Tdap after age 11) (in last ten years): _____/_____/_____
Mo Day Yr

★ **◆ COVID-19** (circle one):

Pfizer, Moderna, or Johnson & Johnson's

1st _____/_____/_____
Mo Day Yr 2nd _____/_____/_____
Mo Day Yr

Booster _____/_____/_____
Mo Day Yr

★ ◆ HEPATITIS B:

1st _____/_____/_____
Mo Day Yr 2nd _____/_____/_____
Mo Day Yr
3rd _____/_____/_____
Mo Day Yr

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

★ ◆ VARICELLA (Chicken Pox):

1st _____/_____/_____
Mo Day Yr 2nd _____/_____/_____
Mo Day Yr

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

★ Tb/PPD Mantoux:

Required for all students at high risk for TB. A second PPD Mantoux is required for health-related curriculums.

★ #1 PPD MANTOUX

Date Administered: _____

Date Read: _____

Result: _____ mm Negative Positive

PPD was positive, a chest x-ray is required. Attach report

★ #2 PPD MANTOUX:

(2nd PPD must be at least one week after the 1st PPD)

Date Administered: _____

Date Read: _____

Result: _____ mm Negative Positive

PPD was positive, a chest x-ray is required. Attach report

***HEALTH CARE PROVIDER SIGNATURE REQUIRED: (LPN, RN, NP, PA, MD/DO) Date: _____**

Name, Title: _____ Signature: _____

Address: _____ Phone: _____

***REQUIRED Meningitis Response Form:**

NYS PHL Section 2167 requires that all students attending college six (6) credit hours or the equivalent per semester complete a Meningitis Response Form. More information can be found on the attached material of this document.

CHECK ONE BOX BELOW, SIGN AND DATE

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

- had meningococcal immunization within the past 5 years. **The vaccine record is attached or has been verified above.**
- decided that I (or my child) will **NOT** obtain immunization against meningococcal meningitis disease at this time. I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I understand that this decision can be changed at any time, and the vaccine may be available at my health care provider or local health department.

***Student's Signature: _____ Date: _____**

Student Name: _____ DOB: _____
Parent/Guardian signature if student is under the age of 18

PART II - PERSONAL HISTORY:

Check if you have ever had or are currently being treated for the following:

- | | | |
|-------------------------------------------------------------|----------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Alcohol/Substance Abuse | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Intestinal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Disabling Condition | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Back Trouble | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Marfan Syndrome |
| <input type="checkbox"/> Blood Disorder (i.e. Sickle Cell) | <input type="checkbox"/> Anxiety/Depression/Other | <input type="checkbox"/> Orthopedic |
| <input type="checkbox"/> Congenital or other heart Problems | <input type="checkbox"/> Mental Health Disorder | <input type="checkbox"/> Thyroid Disease |
| | <input type="checkbox"/> Epilepsy/Seizure Disorder | <input type="checkbox"/> Tuberculosis or TB Contact |
| | <input type="checkbox"/> Head injury/Concussion | <input type="checkbox"/> Other (Explain Below) |

Please explain any checked boxes (severity, dates, therapies, medications, etc.)

Tobacco Use: Never Former – Quit Date: _____ Current
 Type Used (Mark all that apply): Cigarettes Cigars Snuff or Chew E-Cig or Vape Hookah Other: _____

Surgeries and/or severe injuries (include dates): _____

Medications taken at present? No Yes (If Yes, please list medication, dose & reason for taking): _____

Allergies (List all drug, food, and other allergies? No Yes (If Yes, please list with the type of reaction): _____

Family History (List all familial diseases: diabetes, tuberculosis, mental illness, other): _____

***** STOP HERE UNLESS A PHYSICAL IS REQUIRED *****

PART III - PHYSICAL EXAM:

Required for international students and students in Nursing, Physical Therapist Assistant, Health & Fitness Promotion, and Early Childhood curriculums.

Athletes: DO NOT USE THIS FORM. Athletes must use the Athletic Pre-Participation Physical Exam Form found on the Athletic or Health Center’s form web page.

A physical is optional for all other students.

AGE: _____	SEX: _____	B/P: _____	WEIGHT: _____	HEIGHT: _____
VISION FAR: R: 20/ _____ L: 20/ _____		<input type="checkbox"/> without correction		<input type="checkbox"/> with correction
PHYSICAL EXAM	NORMAL	ABNORMAL	COMMENTS	
1. GENERAL APPEARANCE				
2. SKIN				
3. HEENT				
4. NECK				
5. LUNGS				
6. HEART				
7. ABDOMEN				
8. MUSCULOSKELATAL				
9. PSYCHIATRIC				

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

If No, what activities are to be eliminated? _____

*HEALTH CARE PROVIDER SIGNATURE REQUIRED: (NP, PA, MD/DO)	Date of Exam: _____
Name & Title: _____	Signature: _____
Address: _____	Phone: _____

Additional Information Regarding your Health Requirements

New York State Mandatory Immunization Requirements

MMR (Measles, Mumps, and Rubella):

New York State PHL Section 2165 requires students attending post-secondary institutions who were born on or after January 1, 1957 and registered for 6 or more credit hours to demonstrate proof of immunity against measles, mumps, and rubella.

Proof of immunity for MMR consists of:

- **Measles** – Must document two doses of live measles vaccine, *OR* a measles (rubeola) titer showing immunity.
- **Mumps** - Must document one dose of live mumps vaccine, *OR* a mumps titer showing immunity.
- **Rubella** - Must document one dose of live rubella vaccine, *OR* a rubella titer showing immunity.

Meningitis:

New York State PHL Section 2167 requires post-secondary institutions to distribute information about meningococcal disease and immunization to the students (or parents or guardians of students under the age of 18) accompanied by a response form. Acceptable documentation includes any of the following:

- A vaccine record indicating at least 1 dose of meningococcal ACWY vaccine within the last 5 years; *or*
- A signed Meningitis Response Form indicating that the student will not obtain immunization against meningococcal disease.

If the student has not received meningococcal vaccine within the past 5 years, then he/she **must submit the signed response form.*

Required Immunizations by Curriculum

Tuberculin Skin Test

This is not a vaccine, but a test to determine previous exposure to tuberculosis. This test is required for high risk students as defined by the Centers for Disease Control and Prevention. For more information, please refer to the CDC Web site at www.cdc.gov. *Two doses of PPD Mantoux testing given at least one week apart is **REQUIRED** for the following curriculums: Nursing, Physical Therapist Assistant (PTA), and Health and Fitness Promotion (HEFI). Only one PPD test is **REQUIRED** for Early Childhood.*

Varicella Vaccine (chickenpox)

Must document two doses of varicella vaccine *OR* a varicella titer showing proof of immunity. Stated history or even documentation by a medical provider of a history of varicella will not be acceptable proof of immunity. *Note: **Varicella is REQUIRED for Nursing, PTA, HEFI, and Early Childhood students.***

Tetanus, Diphtheria, and Pertussis

After primary series of tetanus, diphtheria and pertussis, one dose of Tetanus toxoid, reduced diphtheria, and acellur pertussis (Tdap) vaccine is recommended after age 11 and a subsequent Td booster every 10 years. *Note: **Nursing, PTA, HEFI, and Early Childhood students are REQUIRED to have proof of Tdap vaccine after age 11 and a subsequent Td booster every 10 years.***

COVID-19

SUNY policy adopts the State of New York directive that public colleges and universities recommend that all students who intend to engage in-person at a SUNY campus or facility receive a COVID-19 vaccination. People are not considered fully vaccinated until 2 weeks after their second dose of the Pfizer-BioNTech or Moderna COVID-19 vaccine, or 2 weeks after a single-dose of Johnson & Johnson's Janssen COVID-19 vaccine. ***REQUIRED for Nursing, PTA, HEFI, and Early Childhood students.***

Recommended Immunizations

Hepatitis B

Series of three doses given prior to college entry is strongly suggested for *all* college students. *It is **REQUIRED** that Nursing, PTA, HEFI, and Early Childhood students show proof of Hep B vaccines or sign a declination/waiver form.*

Physical Examination Requirements

1. International Students

2. Nursing, Physical Therapy Assistant, Health & Fitness Promotion, and Early Childhood students. Students will **not** be allowed to participate in their clinical or fieldwork practice unless this health form/physical examination is on file.

3. Intercollegiate Athletes: DO NOT USE THIS FORM. Athletes need to complete the *Athletic Pre-Participation Physical Exam Form* which is available on the Athletic and Health Center web pages. Be advised that athletes will **not** be allowed to try out for a team or to practice with a team until a pre-admission physical examination is completed.

***For all other students the physical exam is recommended but not required.**

Meningitis Information Sheet

The MenACWY vaccine is recommended for all U.S. teenagers and young adults up to age 21 years. Protection from the MenACWY vaccine is estimated to last about 3 to 5 years, so young adults who received the MenACWY vaccine before their 16th birthday should get a booster dose before entering college. The meningococcal B (MenB) vaccine protects against a fifth type of meningococcal disease, which accounts for about one-third of cases in the U.S. Young adults aged 16 through 23 years may choose to receive the MenB vaccine series.

What is meningococcal disease?

Meningococcal disease is caused by bacteria called *Neisseria meningitidis*. It can lead to serious blood infections. When the linings of the brain and spinal cord become inflamed, it is called meningitis. The disease strikes quickly and can have serious complications including death. Anyone can get meningococcal disease. Some people are at higher risk. This disease occurs more often in people who are:

- Infants younger than one year of age and teenagers or young adults
- Living in crowded settings like college dormitories or military barracks
- Traveling to areas outside of the United States, such as the "meningitis belt" in Africa
- Living with a damaged spleen or no spleen
- Being treated with Soliris® or who have complement component deficiency (an inherited immune disorder)
- Exposed during an outbreak

What are the symptoms?

Symptoms appear suddenly – usually 3 to 4 days after a person is infected. It can take up to 10 days to develop symptoms.

Symptoms may include:

- Weakness and feeling very ill, sudden high fever, Eyes sensitive to light
- Headache and Stiff neck (meningitis)
- Nausea and vomiting
- Red-purple skin rash

How is meningococcal disease spread?

It spreads from person-to-person by coughing or coming into close or lengthy contact with someone who is sick or who carries the bacteria. Contact includes kissing, sharing drinks, or living together. Up to one in 10 people carry meningococcal bacteria in their nose or throat without getting sick.

Is there treatment? Early diagnosis of meningococcal disease is very important.

If it is caught early, meningococcal disease can be treated with antibiotics. But, sometimes the infection has caused too much damage for antibiotics to prevent death or serious long-term problems. Most people need to be cared for in a hospital due to serious, life-threatening infections.

What are the complications?

Ten to 15 percent of those who get meningococcal disease die. Among survivors, as many as one in five will have permanent disabilities. Complications include hearing loss, brain damage, kidney damage and limb amputations.

What should I do if I or someone I love is exposed?

If you are in close contact with a person with meningococcal disease, talk with your health care provider about the risk to you and your family. They can prescribe an antibiotic to prevent the disease.

What is the best way to prevent meningococcal disease?

The single best way to prevent this disease is to be vaccinated. Vaccines are available for people 6 weeks of age and older.

Various vaccines offer protection against the five major strains of bacteria that cause meningococcal disease:

- All teenagers should receive two doses of vaccine against strains A, C, W and Y. The first dose is given at 11 to 12 years of age and the second dose (booster) at age 16. It is very important that teens receive the booster dose at age 16 in order to protect them through the years when they are at greatest risk of meningococcal disease. Talk to your health care provider today if your teen has not received two doses of vaccine against meningococcal A, C, W and Y.
- Teens and young adults can also be vaccinated against the "B" strain. Talk to your health care provider about whether they recommend vaccine against the "B" strain.
- Others who should receive the vaccine include: Infants, children and adults with certain medical conditions; People exposed during an outbreak; Travelers to the "meningitis belt" of Sub-Saharan Africa, and Military recruits.

Additional Information

- [Travel and meningococcal disease](http://wwwnc.cdc.gov/travel/diseases/meningococcal-disease) <http://wwwnc.cdc.gov/travel/diseases/meningococcal-disease>
- [Learn more about meningococcal disease \(cdc.gov\)](http://www.cdc.gov/meningococcal/) <http://www.cdc.gov/meningococcal/>
- [More information about vaccine-preventable diseases](http://www.health.ny.gov/prevention/immunization/) <http://www.health.ny.gov/prevention/immunization/>