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 ☐ Other

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: 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 students to have their own health insurance card or a copy in their possession while at college. A picture of the front and back of the card is sufficient.

STUDENT'S LAST NAME FIRST NAME 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
Anemia		Ear infections		Arthritis		Cancer		
Clotting disorder		Eye issues		Back problems		Epilepsy/Seizures		
Fainting spells		Seasonal allergies				Diabetes		
Heart murmur		Throat infections		Kidney disease		Kidney Disease		
High blood pressure				Kidney stones		Heart Disease		
Palpitations		Chronic diarrhea		Urinary tract infection		High blood pressure		
Sickle cell		Crohn's disease				Other condition (describe in comments below)		
		Hepatitis		ADHD				
Diabetes		Liver or spleen injury		Anxiety				
Thyroid disease		Ulcer or GERD		Depression				
Irregular periods		Ulcerative colitis		Eating Disorder				
				Insomnia				
Asthma		Concussion		OCD				
Pneumonia		Head Injury		Substance use (alcohol/drugs)				
Tuberculosis		Migraines						
		Seizures		**SURGERIES:**				
Chicken Pox		Weakness/Paralysis		Appendectomy				
Lyme Disease				Gallbladder removal				
Mononucleosis		Acne		Hernia repair				
Tumor/cancer		Eczema		Tonsillectomy				
Other condition (describe in comments below)		Psoriasis		Other surgery (describe in comments below)				

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.

_____

PRINT FULL NAME OF STUDENT STUDENT'S DATE OF BIRTH

PARENT/GUARDIAN'S
SIGNATURE_____DATE_____

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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, or at least four (4) semester hours per quarter, complete 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 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 _____ Date _____
(If student is under the age of 18, Parent/Guardian's signature)

Rev. 10.27.23

TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE

Student's 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's Signature (Parent/Guardian if under age 18) Date

STUDENT'S LAST NAME FIRST NAME 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 (Please list below)_____

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

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'S LAST NAME **FIRST NAME** **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

Two 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 #1_____ #2_____ #3_____ #4_____ *Vaccine brand:* _____

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

HEPATITIS B #1_____ #2_____ #3_____

VARICELLA _____ history of chicken-pox Date: _____

OR #1_____ #2_____

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