

Name: _____ Date of Birth: _____

Consent for Treatment: I hereby grant permission to Utica College Student Health Center representatives to render and/or obtain treatment (medical or surgical) necessary to the health and well being of the student named above. I also permit hospitalization if indicated, and I understand that the expenses for such treatment and/or hospitalization shall be my responsibility.

Signature of parent or guardian if student is under the age of 18. Student to sign consent if over 18.

Medical History

Check all listed below that pertain to you and give the date of event or onset of condition.

	Date		Date
<input type="checkbox"/> Allergies/Hay fever	_____	<input type="checkbox"/> Hepatitis C	_____
<input type="checkbox"/> Anemia	_____	<input type="checkbox"/> HIV infection	_____
<input type="checkbox"/> Anorexia	_____	<input type="checkbox"/> Hypertension	_____
<input type="checkbox"/> Anxiety	_____	<input type="checkbox"/> Kidney trouble	_____
<input type="checkbox"/> Appendicitis	_____	<input type="checkbox"/> Low blood pressure	_____
<input type="checkbox"/> Arthritis	_____	<input type="checkbox"/> Malaria	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Measles	_____
<input type="checkbox"/> Back problems	_____	<input type="checkbox"/> Meningitis	_____
<input type="checkbox"/> Binge eating	_____	<input type="checkbox"/> Severe menstrual cramps	_____
<input type="checkbox"/> Bleeding tendencies	_____	<input type="checkbox"/> Migraine headaches	_____
<input type="checkbox"/> Bone/joint problems	_____	<input type="checkbox"/> Mononucleosis	_____
<input type="checkbox"/> Bronchitis	_____	<input type="checkbox"/> Multiple sclerosis	_____
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Mumps	_____
<input type="checkbox"/> Chicken pox	_____	<input type="checkbox"/> Neurological disorder	_____
<input type="checkbox"/> Chronic bronchitis	_____	<input type="checkbox"/> Parasites	_____
<input type="checkbox"/> Colitis	_____	<input type="checkbox"/> Pelvic inflammatory disease	_____
<input type="checkbox"/> Cystic fibrosis	_____	<input type="checkbox"/> Pneumonia	_____
<input type="checkbox"/> Depression	_____	<input type="checkbox"/> Pregnancy	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Rheumatic fever	_____
<input type="checkbox"/> Dizziness	_____	<input type="checkbox"/> Rubella	_____
<input type="checkbox"/> Drug/Alcohol problem	_____	<input type="checkbox"/> Scarlet fever	_____
<input type="checkbox"/> Ear trouble	_____	<input type="checkbox"/> Seizure	_____
<input type="checkbox"/> Eating disorder	_____	<input type="checkbox"/> Sexually transmitted disease	_____
<input type="checkbox"/> Epilepsy	_____	<input type="checkbox"/> Sinus disease	_____
<input type="checkbox"/> Eye injury or disease	_____	<input type="checkbox"/> Skin problems	_____
<input type="checkbox"/> Fainting spell	_____	<input type="checkbox"/> Sleep disturbances	_____
<input type="checkbox"/> Frequent headaches	_____	<input type="checkbox"/> Thyroid trouble	_____
<input type="checkbox"/> Glasses/contacts	_____	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Hay fever/Non-drug allergies	_____	<input type="checkbox"/> Typhoid fever	_____
<input type="checkbox"/> Heart trouble	_____	<input type="checkbox"/> Ulcer; stomach or duodenal	_____
<input type="checkbox"/> Hernia	_____	<input type="checkbox"/> Urinary infections/problems	_____
<input type="checkbox"/> Hepatitis A	_____	<input type="checkbox"/> Wheelchair/Walking apparatus	_____
<input type="checkbox"/> Hepatitis B	_____	<input type="checkbox"/> Other	_____

Please explain any of the conditions checked above that need to be qualified or other items not listed that our office should be aware of or that we can be of assistance with:

Drug Allergies and Reactions: (List separately) _____

Current Medications: _____

List and detail all major surgeries: _____

Physical Examination

Name: _____ Date of Birth: _____

To the Physician: The Student Health Center strives to see that every student is physically and mentally prepared for the challenges of college life. The American Academy of Pediatrics and Family Practice recommends that you use this time to discuss safe health practices that can benefit your patient, such as seat belt use; cigarette, alcohol, and drug abuse; and sexual activity.

A. Health Examination

Ht. _____ Wt. _____ Blood Pressure _____ Pulse _____

Urinalysis: Protein _____ Glucose _____

Mantoux Tuberculin skin test: Results _____ Date _____

Chest x-ray required if skin test is positive. Date _____ Results: Negative Positive

Normal=N; Abnormal=A

N A

Comments: Abnormal Findings: label by number

1. Appearance	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Skin/Nose	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Head/Scalp	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Ears	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Mouth, teeth and gums	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Chest/Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Musculo-skeletal	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. Neurological	<input type="checkbox"/>	<input type="checkbox"/>	_____
13. Alertness	<input type="checkbox"/>	<input type="checkbox"/>	_____
14. Emotional/Mental (behavior problems)	<input type="checkbox"/>	<input type="checkbox"/>	_____
15. Handicap, Physical/Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	_____
16. Activity restrictions (specify)	<input type="checkbox"/>	<input type="checkbox"/>	_____
17. Abuse, Substance/Physical/Emotional	<input type="checkbox"/>	<input type="checkbox"/>	_____
18. Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	_____
19. Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

B. Health History: (serious illnesses, injuries: explain) _____

(attach narrative if additional space needed)

C. May this person participate in intercollegiate or intramural sports? Yes No

I have reviewed the clinical history and physical examination and certify that this person will be able to participate in all activities of college life. (Please Print)

Health Care Provider: _____ Phone: _____

Name of Clinic: _____

Address: _____ City: _____ State: _____ Zip: _____

Authorized Signature: _____ Date: _____

M.D., N.P. or PA

Health Care provider, please see page 4

Immunization Record

International students must provide English transcript of immunization history.

Name: _____ Date of Birth: _____
Last First MI

Part I – To be completed and signed by student or parent/guardian for student under the age of 18

Meningococcal vaccine (recommended for freshmen living in residence halls. Non-freshmen under 25 years of age may choose to be vaccinated to reduce the risk of meningococcal disease.) Check box if not receiving vaccine. Visit www.vaccineinformation.org for more information on meningitis.

- 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 have decided that I (my child) *will not* obtain immunization against meningococcal meningitis disease.

Signed: _____ Date: _____

Part II – To be completed and signed by your health care provider.

All information must be in English.

A. M.M.R. (Measles, Mumps, Rubella) (Two doses required by NYS Law)

1. Dose 1 given at age 12-15 months or later #1 ____/____/____
Mo. Day Yr
2. Dose 2 given at age 4-6 years or later and at least one month after first dose #2 ____/____/____
Mo. Day Yr

OR

1. Titers: Measles _____ Mumps _____ Rubella _____

(Attach copy of positive titers)

B. Meningococcal vaccine (Recommended by NYS)

- Meningococcal Conjugate Menactra™ (Preferred) ____/____/____ Date
Mo. Day Yr

OR

- Meningococcal Polysaccharide Menomune™ (Acceptable alternative if conjugate is not available. Revaccinate every 3-5 years.)
____/____/____ Date
Mo. Day Yr

C. Tetanus-Diphtheria: (Required by NYS law within last ten (10) years)

1. Tetanus-diphtheria booster ____/____/____ Date of last booster
Mo. Day Yr

D. Hepatitis B Vaccine: Three-dose series (recommended by NYS)

- #1 ____/____/____ #2 ____/____/____ #3 ____/____/____
Mo. Day Yr Mo. Day Yr Mo. Day Yr

E. Varicella Vaccine (Chicken Pox): Strongly **recommended** if no history of illness

____/____/____ Date of vaccine
Mo. Day Yr

____/____/____ Date of illness
Mo. Day Yr

Health care provider signature or stamp **required** (M.D., N.P., P.A., R.N.)

I have reviewed the clinical history and verify that this person has been immunized as noted above.

Signature: _____

Name (print): _____

Title: _____

Address: _____

City: _____ State: _____ Zip: _____

Date: _____

State in which licensed: _____ Phone: _____

Important! Make a copy of this form for your personal record.