

Student Name: _____ DOB: _____ Banner #: _____



The College at
BROCKPORT
STATE UNIVERSITY OF NEW YORK
Student Health Center, Hazen Hall
350 New Campus Drive
Brockport, NY 14420
Ph: (585) 395-2414 Fax: (585) 395-2559

For Administrative Purposes Only:		Date	Initials
	Immunizations entered	_____	_____
	Health Hx reviewed by RN	_____	_____
Athletes Only	Forms Complete	_____	_____
	Reviewed by SHC provider	_____	_____
<input type="checkbox"/> Not Cleared:	<input type="checkbox"/> Ortho	<input type="checkbox"/> Asthma	<input type="checkbox"/> Cardio
	<input type="checkbox"/> Single Organ	<input type="checkbox"/> Trainer	_____
	<input type="checkbox"/> Other	_____	_____
<input type="checkbox"/> Cleared	Date: _____	Signature: _____	

MEDICAL EVALUATION FORM

Due Before Classes Begin

Instructions and Information — Important — Please Read!

Before classes begin, the **MANDATORY IMMUNIZATION INFORMATION** must be returned to the Student Health Center. A completed Health Assessment and Physical Exam *is required for athletes* and is highly recommended for all other students.

PERSONAL INFORMATION

Part I

PLEASE TYPE OR PRINT

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

Home Address: _____
(Street) (City) (State) (Zip) (Country)

Gender: Male Female Check all that apply: Athlete _____ International Student _____
(Sport) (Country)

IN CASE OF AN EMERGENCY

Parent/Guardian/Other:

Name: _____

Relationship to Student: _____

Address: _____

Phone: (H) (____) _____ (W) (____) _____

Cell: (____) _____

Primary Care Physician:

Name: _____

Address: _____

Phone: (____) _____

Fax: (____) _____

HEALTH INSURANCE INFORMATION

Health insurance is mandatory for all full-time undergraduate and graduate students enrolled in 12 or more credits. All full-time students are automatically charged for the college sponsored insurance plan on their student bill. If you have health insurance coverage, you may **waive the insurance charge online** by completing an electronic waiver by the deadline. Please see the waiver instructions at www.brockport.edu/healthctr/insurance

Bring a copy of your insurance card to school. **Please also submit a copy of both sides of your insurance card to be kept on file in the Health Center.** Be aware of any restrictions to your coverage such as copays, deductibles or out of area coverage.

PERMISSION FOR TREATMENT OF STUDENTS UNDER 18 YEARS OF AGE

For parents/guardians of Applicants under 18 years of age: In order to provide routine and/or emergent medical care or immunizations, please sign the consent below. Parental contact will be made at the discretion of the healthcare provider.

I, _____, pursuant to the authority vested in me as parent/guardian of _____
Parent/Guardian Student's Full Name

do hereby authorize the medical staff of The College at Brockport upon consultation with a licensed healthcare provider, to exercise for me and on my behalf, all rights and duties with reference to consenting to appropriate medical, psychiatric and surgical treatment, anesthetics, medicine, and hospitalization, including care and treatment by any hospital or staff provider which they deem necessary for the treatment of my son/daughter.

Signed (parent/guardian) _____ Date: _____

ATHLETES ONLY: CONSENT TO SHARE INFORMATION

I give permission to the Student Health Center staff to share medical information with the Athletic Department as it relates to athletic participation.

Student Signature _____ Date: _____

(or Parent/Guardian if student under 18 years)

Student Name: _____ DOB: _____ Banner #: _____

MANDATORY IMMUNIZATIONS

Part II

— Due Before Classes Begin —

30 Days after the start of classes, students failing to provide immunization information will be de-registered and unable to attend classes. There is a fee to re-register. Submit this form **OR** immunization records from your school/personal physician.

Fax to (585) 395-2559; or mail to: Student Health Center, Hazen Hall, 350 New Campus Drive, Brockport, NY 14420.

MMR (MEASLES, MUMPS, RUBELLA) PROOF REQUIRED IF BORN ON OR AFTER 1/1/1957	VACCINE DATE (MONTH/DAY/YEAR)	OR	PHYSICIAN DIAGNOSED DISEASE (DATE OF ONSET)	OR	SEROLOGY (RESULTS/DATE)
2 MMR's Combination Measles, Mumps & Rubella vaccine 1 st dose after 1 st birthday; 2 nd dose at least 28 days later.	#1	X	X	X	X
	#2				
OR list individual vaccines below 2 MEASLES 1 st dose after 1 st birthday; 2 nd dose at least 28 days late	#1				Must attach lab results
	#2				
1 MUMPS After 1 st birthday					Must attach lab results
1 RUBELLA After 1 st birthday			History of Rubella disease does not prove immunity		Must attach lab results

MENINGITIS INFORMATION RESPONSE FORM

New York State Public Health Law §2167 requires our students to learn about Meningitis and be aware of the availability of the meningitis vaccine (available at a cost from your health care provider or Student Health Services). While you are not required to receive this vaccine, we strongly urge you to read the full information regarding meningitis at www.brockport.edu/healthctr/immunizations and to consider immunization.

New York State Public Health Law requires you to select one of the statements below and provide your signature:

- I have received the immunization for meningitis within the past 10 years. **Date received:** _____
- I acknowledge the risks associated with meningitis and decline immunization.

Signed: _____ **Date:** _____
 Student Signature (or Parent/Guardian if student under 18 years)

RECOMMENDED VACCINES	VACCINE DATE (MONTH/DAY/YEAR)		
Hepatitis A	#1	#2	
Hepatitis B	#1	#2	#3
Human Papilloma (HPV)	#1	#2	#3
Polio	#1	#2	#3
Tetanus/Diphtheria (most recent)	Circle: Td <i>or</i> Tdap (most recent dose)		
Varicella	#1	#2	OR year of chicken pox disease
Tuberculin Skin Test (PPD)	Date:	Results:	CXR required if PPD positive. Document follow-up separately.

I certify that the above is complete and accurate.

Healthcare Provider Name: _____
Print or Stamp

Address: _____
(Street) (City) (State) (Zip)

Phone: (_____) _____ Fax: (_____) _____

Healthcare Provider Signature: _____ Date form completed: _____

Student Name: _____ DOB: _____ Banner #: _____

PERSONAL HISTORY (to be completed by student and/or parent)

Part III

Check boxes to indicate whether you have any of the following medical conditions. Explain "Yes" answers below. List Dates.

Y	N		Y	N		Y	N		Y	N	
		Anemia/Blood Disorder			Gynecological Problem			Hepatitis or Liver Disease			Tuberculosis or positive PPD
		Sickle Cell Anemia			Mononucleosis			Cancer			Physical Disability
		Autoimmune Disease (lupus, rheumatoid)			Gastrointestinal Disorder (ulcer, IBS, GERD)			Thyroid Disorder			Learning Disability
		Diabetes			High Cholesterol			Neuromuscular Disease (MS, Cerebral Palsy)			Visual Impairment
		Eating Disorder			High Blood Pressure			Seizure Disorder (Date of Last Seizure)			Hearing Impairment
		Lung Disease (pneumothorax, cystic fibrosis)			Heart Disease/Murmur (Marfans, Long QT, Irregular Heartbeat)			Hernia or Rupture			Psychological Problems (Anxiety/Depression)
		Asthma (inhaler use)			Migraine/Headache			Skin			Alcohol/Drug Problem
		Orthopedic Injuries/Surgeries			Loss of Consciousness			Surgeries (explain)			Overnight Hospitalizations (explain)
Y	N		Y	N	Concussion/Head Injury						
		Neck			Hands						
		Back			Legs						
		Arms			Knees						
		Shoulder			Ankles						
					Kidney Disease/Stone/UTI						

Explain: _____

Have you ever had (especially with exercise)	Y	N	If YES, please explain:
Difficulty breathing, wheezing or chest pain?			
Dizziness, lightheadedness or fainting?			
Heat exhaustion, heatstroke or other problem with heat?			
Any loss of use of a paired organ: eye, kidney or testicle?			Which organ?
Have you ever had an echocardiogram or EKG?			Why? and When?

Do you have any allergies (ie: medications, latex, insects, anesthesia)? Yes No If Yes, Please list.

List all medications currently being taken. Provide details below.

MEDICATIONS	DOSAGE	FREQUENCY	REASON

FAMILY HISTORY (to be completed by student and/or parent)

Check boxes to indicate if condition exists in your family (immediate family, grandparents, etc.) Provide details below.

Y	N		Y	N		Y	N	
		Anemia/Blood Disorders			Diabetes			Marfans Syndrome
		Sickle Cell Disease			Kidney Disease			Stroke/Hemorrhage
		Asthma/Allergies			Heart Disease			Sudden Death before age 50
		Autoimmune Disease			High Blood Pressure			Psychiatric Disorders
		Cancer			Long QT Syndrome			Alcohol/Drug Problem

Explain: _____

The questions on this form have been answered completely and truthfully to the best of my knowledge.

Student Signature: _____ Date: _____

Student Name: _____ DOB: _____ Banner #: _____

PHYSICAL EXAMINATION

Part IV

Required by the NCAA for all new athletes—Recommended for all other students

TO THE LICENSED HEALTH PROFESSIONAL (D.O., M.D., P.A., N.P.) PERFORMING THIS EVALUATION:
 Please review the Health History completed by the student on the previous page and provide additional details as needed.
 Please complete the physical examination and comment on all positive findings.

Height: _____ inches Weight: _____ lbs. BMI: _____ BP: _____ Pulse: _____ Vision: Right 20/____ Left 20/____
 Hearing: Right: _____ Left: _____ Glasses? _____ Contacts? _____ Dental Appliance: YES NO Type: _____
 *Date of Sickle Cell Solubility Test: _____ Result: _____ ***RECOMMENDED** by the NCAA for ALL Student-Athletes regardless of ethnicity, family history, etc.

HISTORY

To your knowledge does the student have any history of the following:

	Yes	No	EXPLANATION
Arrhythmias/Murmurs			
Chest Pain			
Dyspnea on Exertion			
Shortness of Breath			
Family History of Heart Disease			
Syncope/Fainting			

PHYSICAL EXAM

	NORMAL	ABNORMAL	EXPLANATION
HEENT			
Neck/Thyroid			
Lungs/Chest			
Cardiovascular			
Abdomen/Testicles			
Musculoskeletal/Spine			
Extremities			
Skin			
Neurologic/Psychiatric			

Physical Examination: Are there any conditions of which we should be aware (such as single organs, hematologic disorder, seizure disorder, recent surgery, recurrent infections)? Describe fully. Use additional sheet if necessary.

PROVIDER INFORMATION: Date of Exam: _____ (Per NCAA, this exam must be completed no sooner than 6 months prior to the start of the sport.)

I have reviewed the information above and make the following recommendations for his/her participation in athletics:
 Cleared Not Cleared Cleared—f/u needed (explain below)

F/U Recommendations: _____

I have conducted a physical examination of this patient. All medical/psychiatric conditions and therapies are noted above or on attached pages.

Healthcare Provider Name: _____
Print or Stamp

Address: _____
(Street) (City) (State) (Zip)

Phone: (_____) _____ Fax: (_____) _____

Healthcare Provider Signature: _____ Date form completed: _____