

Family History

Part II

	Age	State of Health	Occupation	Age of Death	Cause	Immediate Family History	Yes	No	Relationship
Father						Arthritis			
Mother						Asthma/Hayfever			
Brother						Cancer			
						Convulsions/ Seizures			
						Diabetes			
						Digestive Problems			
						Drug/Alcohol Abuse			
Sister						High Blood Pressure			
						Heart Disease/ Stroke			
						Kidney Disease			
						Mental Illness			
						Tuberculosis			
						Other			

Personal Health History (Please answer all questions. Explain all "Yes" answers)

Part III

Have You Had	Yes	No	Have You Had	Yes	No	Have You Had	Yes	No
Alcohol/Drug Problem			Gynecologic Problem			Rheumatic Fever		
Asthma			Hayfever/Environmental Allergies			Skin Conditions		
Back Problems			Headaches (Recurrent)			Tuberculosis		
Blood Disorders/Anemia			Head Injury/ Unconsciousness			Urinary Tract Infection		
Cancer			Heart Murmur			Painful Urination		
Cerebral Palsy			Heart Palpitations			Unexplained Weight Loss or Gain		
Convulsive/ Seizure Disorder			Hernia			Allergy to: Penicillin		
Corrective Lenses			High Blood Pressure			Sulfa		
Chicken Pox (disease)			Impaired Hearing			Vaccines		
Diabetes			Impaired Vision			Foods		
Depression/Psychological conditions			Jaundice/Hepatitis			Other		
Disease/Injury of Joints			Malaria			Surgery: Appendectomy		
Ears, Nose, Throat Problems			Mononucleosis			Tonsillectomy		
Eating Disorder (Anorexia/Bulimia)			Neuromuscular Problems			Other		
Frequent Colds/Sinusitis			Orthopedic Problems			Ongoing health problems		
Gall Bladder Problem			Pelvic Inflammatory Disease			Any physical activity restrictions		

Explanation: _____

Do you take any medications? Please list names and doses _____

Immunization Status

Part IV

New York state law requires immunization information for all students born after 1956. **Two Measles** immunizations after one year of age and at least 30 days apart, **OR** physician diagnosed and documented disease, **OR** a copy of the positive titer report plus one dose mumps and one dose German measles is **MANDATORY**. The following immunizations must be administered **after** the 1st birthday **AND after** 1/1/68.

MANDATORY OR students will be dropped from classes 30 days after start of school.

Disease month/day/year	Vaccination Type month/day/year	Vaccination Type OR Must attach copy of results	Serology Date history and signature	OR MD diagnosed disease
Measles (Rubeola) <input type="checkbox"/> 2 doses OR MMR <input type="checkbox"/>	#1	#2		
Mumps - one dose		N/A		
German Measles (Rubella) one dose		N/A		N/A

I certify that the above MMR information is correct _____
Physician/Provider Signature

MANDATORY *Meningococcal Meningitis* information: immunization date OR gave declination of vaccine.
 If not received, students will be dropped from classes 30 days after the start of school.

During the **PAST 10 YEARS** have you received Meningococcal Meningitis (Menomune A,C,Y & W135) vaccine?

YES ____/____/____ NO I decline the vaccine (sign below)
Date received

I have read the information regarding Meningococcal Meningitis provided to me by the college. I am aware that this immunization is not required but is available at a reasonable price *at the Student Health Center, from my own health care provider, or at Monroe County Health Department.*

Student signature _____ Date _____

STRONGLY RECOMMENDED

Tetanus-Diphtheria: must be within the past 10 years.

Date Primary series completed: _____ Date of last booster: _____

Polio:

Date series completed: _____

Hepatitis B Vaccination Series

Date 1st dose administered: _____ Date 3rd dose administered: _____
 Date 2nd dose administered: _____ Date of booster as appropriate: _____

TB screening within the past year is **required** of all students at high risk for TB as defined by the CDC (i.e., foreign born persons from high prevalence countries, persons with compromised immune systems, close contacts of infectious TB).

Mantoux PPD skin test within the past year

Date administered: _____ Results _____
 Date read: _____ mm Transverse Dimension _____
 Chest x-ray required if positive PPD
 Date & Results: _____ Treatment Received: _____

Varivax (Varicella/Chicken Pox) if no history of disease

Date: _____

Medical Exemption:

_____ is exempt from receiving _____
Name of Student Name of Immunization

for the following medical reasons: _____

 Signature of Physician/Provider

 Date

Physical Examination

Part V

To be completed by your health care provider.

Ht. _____ B/P _____ Vision Rt. 20/ _____ Corrective lens _____
 Wt. _____ HR _____ Vision Lt. 20/ _____ Corrective lens _____

Laboratory Data:

Hct. or Hgb. _____
 Urinalysis: Protein _____ Glucose _____
 Other labs at discretion of examiner:

Check each item in the proper column. Enter NE if not examined.

	Normal	Abnormal	Description
1. Head, Ears, Eyes, Nose, Throat			
2. Neck (Thyroid)			
3. Lungs, Chest			
4. Breasts			
5. Vascular System			
6. Heart			
7. Abdomen (Including Hernia)			
8. Ano-rectal (pilonidal)			
9. Endocrine System			
10. Genito-urinary System			
11. Upper Extremities			
12. Lower Extremities			
13. Spine, Musculo-skeletal			
14. Skin and Lymphatics			
15. Neurologic, Psychiatric (Specify disorder)			

16. Is there a loss or seriously impaired function of any paired organ? Yes _____ No _____
 17. Is the student currently under treatment for any medical or emotional condition? Yes _____ No _____
 18. Are there any restrictions on activities for physical education or intramural sports? Yes _____ No _____

Explanation: _____

Upon completion of a complete physical examination, I have found _____

Student's Name

capable of participating in a full program of college study, including participation in intercollegiate sports and/or nursing clinical activities.

Signature of Physician/Health Care Provider

Date

Printed Name, Address and Phone Number of Health Care Provider