

HEALTH REPORT AND PHYSICIAN'S CERTIFICATE

Return to:
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SUNY New Paltz, 1 Hawk Drive, New Paltz, New York 12561-2443

HEALTH INFORMATION FOR STUDENTS, PARENTS AND PHYSICIANS

HEALTH REPORT AND PHYSICIAN'S CERTIFICATE and MEDICAL RELEASE FORM. The completed form should be mailed by the examining physician to the office indicated above. This form should be on file at least one month before a student's arrival on campus. Students whose completed Health Certificate is not on file at the Student Health Service may not be seen at the Student Health Service and may be referred to their personal physician for care.

Basic to good student health care is the College's knowledge of the health status of each student. This Health Report and Physician's Certificate Form is the foundation of each student's medical record at the College, and thus a critical element in that knowledge. The information provided by this form will be reviewed by the Student Health Service's professional staff and, if necessary, referred to the college physician for evaluation. It is then filed for reference to be used whenever a consultation for illness or a conference for health appraisal takes place. *A release form is enclosed which must be completed and sent with the Health Report to our office. This form will allow us to communicate confidential health information to the student's physician. This release form will remain in effect until revoked by the student.*

A good medical record enables better health service and health guidance of a student than would be possible without it. For this reason, it would be appreciated if considerable care is used in filling out this form.

The information contained in this form is accessible only to the professional staff of the Student Health Service and will not be released without the written authorization of the student or pursuant to law. The authority to request this information is found in section 355 of the Education Law of New York State.

MANDATORY FOR PARENTS AND GUARDIANS OF STUDENTS BELOW 18 YEARS OF AGE:

In Order to procure care that may be necessary for students and at the same time to protect physicians and institutions involved, it is requested that you sign and have notarized the consent for treatment below.

Be assured that we make every effort to notify parents at once in case of serious accidents or illnesses when these come to our attention, but since students often come from great distances, this may be slow or impossible even by phone. Your cooperation in this matter, therefore, is much appreciated.

I _____ pursuant to the authority vested in me as _____ of _____ do hereby authorize the

medical staff of SUNY New Paltz upon consultation with a practicing physician or surgeon to exercise for me and on my behalf, all rights and duties with reference to consenting to appropriate medical psychiatric and surgical treatment, anesthetics medicines and hospitalization, including care and treatment, by any hospital, staff surgeon, physician or radiologist which they may deem necessary for the emergency care of my

SON/DAUGHTER

STUDENT NAME

Signed _____ Date _____

Subscribed before me this _____ day of _____ 20 _____

PARENT

Notary Stamp and Seal

Notary Signature _____

STUDENT HEALTH SERVICE • SUNY NEW PALTZ
HEALTH REPORT AND PHYSICIAN'S CERTIFICATE
Please print or type all information. Thank you.

Name: _____ Date of Birth: _____
LAST FIRST MIDDLE

Student Cell Phone #: _____ Banner ID: _____

Permanent Address: _____
STREET CITY STATE ZIP

Student E-mail Address: _____

Student Mailing Address (if different from permanent mailing address):

Parent or Guardian: _____ Phone Number(_____) _____

Address: _____
STREET CITY STATE ZIP

Health Insurance: _____
company ID # Policy Holder

Primary Physician: _____ Phone Number(_____) _____

Address: _____
STREET CITY STATE ZIP

Family History: (List all familial diseases: Diabetes, Tuberculosis, Mental Illness, Other): _____

Person to notify in case of emergency: Name: _____

Address: _____ Phone (Home): _____

_____ Phone (Office): _____

Phone (Cell): _____

MENINGITIS INFORMATION RESPONSE FORM

New York State Public Health Law requires that all university students enrolled for at least six (6) semester hours or the equivalent per semester, complete the following:

Please note that according to NYS Public Health Law, no institution shall permit any student to attend the institution in excess of 30 days without complying with this law. The 30 day period may be extended to 60 days if a student can show a good faith effort to comply.

Check one box and sign below, after reading the enclosed Meningitis handout sheet:

- Had the Meningococcal meningitis immunization within the past 10 years.
Date received: _____ (Provide medical documentation.)

- 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: _____

*To be completed and signed by Parent/Guardian if student is a MINOR.

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Student's Last Name: _____ First _____ MI _____ Date of Birth: _____

PERSONAL HISTORY

Check those of the following diseases or conditions the student has had:

- | | | | |
|---|---|---|---|
| Y N | Y N | Y N | Y N |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emotional Disorder | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Positive TB Skin Test |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Malaria | <input type="checkbox"/> Psychiatric Disease |
| <input type="checkbox"/> Attention deficit hyperactivity disorder | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Malignancy | <input type="checkbox"/> Residual Impairment of hearing |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Frequent Sore Throats | <input type="checkbox"/> Measles (<input type="checkbox"/> English or Red <input type="checkbox"/> Rubella German) | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Chronic intestinal problems | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Congenital or other Heart Problems | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Mumps | <input type="checkbox"/> Speech Impairment |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hives | <input type="checkbox"/> Orthopedic problems | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Infectious Jaundice or Hepatitis | <input type="checkbox"/> Otitis Media | <input type="checkbox"/> Surgeries |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tonsillitis |

Explain any yes answers: _____

Americans with Disabilities Act: Do you have any condition that to your knowledge falls under the jurisdiction of this law? No Yes

Condition: _____

Number of days of illness last year: _____ Cause(s): _____

Injuries: Yes No Explain: _____

Any medicine, food or other allergies? Yes No Specify: _____

Epi Pen required Yes No Prescribed Yes No

Medical problems other than listed above? Yes No Specify: _____

Name & signature of person completing the section above _____

THE COLLEGE REQUIRES THE FOLLOWING IMMUNIZATIONS

IF NOT COMPLETED ACCORDING TO NYS LAW, STUDENT MAY BE DE-REGISTERED.

This section to be completed by medical practitioner:

		RECORD INDIVIDUAL DATES OF EACH DOSE					Last DT Tdap
		1st dose	2nd dose	3rd dose	4th dose	5th dose	
Three or more doses required. Most recent dose must be within 10 year prior to entry.	Diphtheria & Tetanus toxoid						
Minimum of 3 doses for all students 18 and under. For those 19 and over, record previous doses but no additional doses should be given.	Polio Vaccine						
One dose LIVE Vaccine given after first birthday. Serologic proof of immunity is acceptable in lieu of vaccine, but a copy of lab results must be attached.	Rubella	M/D/Y					
	Mumps	M/D/Y					
Two doses LIVE vaccine: #1 after first birthday, #2 at least 90 days after the first dose. Serologic Proof of immunity is acceptable in lieu of vaccine, attach lab results.	Measles	M/D/Y	M/D/Y				
		OR				MMR #1	MMR #2
					M/D/Y	M/D/Y	

LAST MANTOUX (Intradermal) TUBERCULIN SKIN TEST <i>If positive, required to send copy chest x-ray and INH treatment record</i>	Date Administered	Date Interpreted	Result
			MM of induration:

UNIVERSALLY RECOMMENDED IMMUNIZATIONS FOR ALL YOUNG ADULTS:

Hepatitis B _____ M/D/Y _____ M/D/Y _____ M/D/Y *Meningococcal _____ M/D/Y _____ Varicella Disease _____ M/D/Y

**Gardisil (HPV): _____ M/D/Y _____ M/D/Y _____ M/D/Y Specify: Menactra vs. Menomune Titer: _____ M/D/Y

*Vaccine strongly recommended for all first year students living on campus. Varicella Vaccine _____ M/D/Y

**Females only

MD/DO/NP/PA Office Stamp:

PA must identify supervising physician Physician or Designee Signature: _____ Date _____

PHYSICAL EXAMINATION

Sex:	Age:	Height:	Weight:	BMI:
Blood Pressure:	Pulse:	Build: <input type="checkbox"/> Slender <input type="checkbox"/> Medium <input type="checkbox"/> Heavy <input type="checkbox"/> Obese		
Color Vision:	(test used)	Hearing: Right Left		
Vision: Far: Right 20/	Corr. to 20/	Far: Left 20/	Corr to 20/	

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CLINICAL EVALUATION

Student's Name: _____

Date of most recent physical examination: _____

Check each item in proper column.

	NORMAL	ABNORMAL	NOT EVALUATED	NOTE: Give details of each abnormality with corresponding item numbers
1. Head, Neck, Face and Scalp				
2. Nose and Sinuses				
3. Mouth and Throat				
4. Teeth and Gingiva				
5. Ears (perf. of drum, etc)				
6. Eyes (lids, conjunctiva, etc.)				
7. Pupils and Ocular Motion				
8. Lungs, Chest, and Breasts				
9. Heart (include estimate of cardiac function)				
10. Vascular System (varicosities, etc.)				
11. Abdomen and Viscera (include hernia)				
12. Ano-rectal (pilonidal)				
13. Endocrine System				
14. G-U System				
15. Upper Extremities (strength, range of motion)				
16. Feet				
17. Lower Extremities (strength, range of motion)				
18. Spine, other Musculo-skeletal				
19. Skin and Lymphatics				
20. Neurologic				
21. Psychiatric				

LAB DATA:	Hgb.	W.B.C.	Urinalysis	Alb.	Sug.	Sed.
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Current Medications: _____

For any chronic health problems please list specialists and contact information

Is this student able to participate in all physical activity? Yes No If "No" what activities are to be eliminated?

Is there (or has there ever been) evidence of significant anxiety or emotional instability? Yes No

If so please indicate how the college may be of help to this student.

After considering the history and physical examination, what is your professional opinion of this applicant's ability to meet the physical and emotional demands of college life, and of varsity athletic competition, where applicable:

Do you recommend further investigation or treatment? Yes No Specify: _____

Will you remain involved in patients health care? Yes No

Name of examining clinician (please print): _____ Specify: MD/DO/NP/PA*:

*PA must identify supervising physician

Jurisdiction of License: _____ Registration #: _____ Telephone: () _____

Address: _____

Signature: _____ Date: _____