



Health History Form

LoGrasso Hall Health Center

Phone: 716-673-3131

Fax: 716-673-4722

This form, including the immunization record, must be completed and returned to the Health Center six weeks prior to the beginning of classes. Mail form to: LoGrasso Hall Health Center, SUNY at Fredonia, Fredonia, NY 14063.

PLEASE NOTE: Failure to comply with the mandatory immunization requirement may result in registration procedures being delayed or reversed.

Female Male

Date of Birth

Social Security No.

Last Name (Please Print) First Middle Citizenship

Permanent Address (Number and Street) City or Town State Zip Code

Name, Relationship, and Address of Next of Kin Home Telephone Number

Work Telephone Number

HEALTH INSURANCE INFORMATION

Name of Insurance Carrier _____

Policy No. _____ Group No. _____

Person policy is listed under _____

Is this insurance an HMO plan? _____

Please check the following coverage you have:

Prescriptions _____ Lab work _____ In-hospital care _____ Dental _____

Does your insurance require a referral or authorization from your Primary care physician (PCP) before care is given?

Please include the name, address and phone number of your PCP or family physician.

Physician Name _____

Address _____ Phone No. _____

Consent for Medical Care - To the Parents/Guardians of Applicants under 18 Years of Age Only

In order to procure any necessary medical care and to protect the clinicians and institutions involved, please sign the consent for medical treatment below. Be assured that we make every effort to notify parents at once in case of major injuries or serious illnesses.

I (your full name) _____, pursuant to the authority vested in me as the parent/guardian of (student's full name) _____

do hereby authorize the clinical staff at SUNY Fredonia's Student Health Service to provide routine medical care to my son/daughter. This care may include treatment of common illnesses, physical examinations for sports participation, ordering of laboratory tests, prescribing of medications and the administration of immunizations to meet New York State immunization requirements. Furthermore, I do hereby authorize the clinical staff of the State University of New York College at Fredonia to seek emergency medical care from outside clinicians if they feel it is necessary.

Notary Public
(with seal required)

Parent/Guardian Signature

Signed _____

Subscribed before me this _____ day of _____ 20 _____

LoGrasso Hall Health Center - SUNY Fredonia

IMMUNIZATION RECORD

Name _____ Date of Birth _____

REQUIRED by New York State Public Health Law 2165

ALL Students taking 6 or more credit hours **MUST** provide proof of protection against measles, mumps, and rubella. All those born prior to January 1, 1957 are exempt from this requirement.
ALL Students must complete meningococcal meningitis section.

MANDATORY IMMUNIZATIONS

MUST List Exact Dates (Month, Day, Year) For ALL Immunizations.

	1st	2nd
MMR (Combined Measles, Mumps and Rubella) Two doses of live vaccine after 1/1/72. #1 After first birthday - #2 After 15 months of age or at least 30 days after the first OR		
Measles (Rubeola) Two doses of live vaccine: #1 After the first birthday and after 1/1/68 - #2 After 15 months of age or at least 30 days after the first		
Mumps One dose of live vaccine after the first birthday and after 1/1/69.		
Rubella One dose of live vaccine after the first birthday and after 1/1/69. OR		
★★COPY OF: Serologic Proof of Measles, Mumps and Rubella is acceptable.		

PPD (Mantoux) TUBERCULIN SKIN TEST - Required within the last 12 months.

Date Placed: Month/Day/Year	Date Read: 48-72 Hours Later	Results: _____ mm in duration
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If positive, a chest x-ray done in the USA is required. Please include a copy of the chest x-ray report.

Chest X-Ray Date *	Results:
If negative CXR and Positive PPD, was INH offered?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused
Was Treatment Given? Explain. (Length of treatment/months).	

MENINGOCOCCAL MENINGITIS VACCINE - RESPONSE REQUIRED

TO BE COMPLETED AND SIGNED BY STUDENT OR PARENT/GUARDIAN FOR STUDENT UNDER THE AGE OF 18 (One dose within 10 years recommended by NYS PHL §2167)

CHECK ONE (1) BOX ONLY

- I have received meningococcal meningitis vaccine (Menomune™) within the last 10 years - Date / /
- 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 _____
(STUDENT SIGNATURE - PARENT IF UNDER 18)

RECOMMENDED IMMUNIZATIONS

Tetanus-Diphtheria: must be within 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: _____

Varivax (Varicella/Chicken Pox) if no history of disease Date #1 _____ #2 _____

ALL IMMUNIZATIONS MUST BE SIGNED BY A HEALTH CARE PROVIDER
 I certify that the above immunization record is accurate.

 Signature of Health Care Provider

 Date

NAME: _____

MEDICAL HISTORY

To be completed by student.

PERSONAL HEALTH HISTORY (Please answer all questions. Explain all "YES" answers.)

Have You Had?	Yes	No	Have You Had?	Yes	No	Have You Had?	Yes	No
Alcohol/Drug Problem			Ears, Nose, Throat Problems			Impaired Hearing		
Anxiety/Panic Attacks			Eating Disorder (Anorexia/Bulimia)			Impaired Vision		
Asthma			Frequent Colds/Sinusitis			Jaundice/Hepatitis		
Back Problems			Gall Bladder Problem			Mononucleosis		
Blood Disorders/Anemia			Gynecologic Problem			Neuromuscular Problems		
Cancer			Hayfever/Environmental Allergies			Orthopedic Problems		
Cerebral Palsy			Headaches (Recurrent)			Pelvic Inflammatory Disease		
Convulsive/Seizure Disorder			Head Injury/Unconsciousness			Rheumatic Fever		
Corrective Lenses			Heart Murmur			Skin Conditions		
Chicken Pox (disease)			Echocardiogram Done?			Tuberculosis		
Depression			Heart Palpitations			Urinary Tract Infection		
Diabetes			High Blood Pressure			Unexplained Weight Loss or Gain		
Disease/Injury of Joints								

Explanation: _____

Please list:

Current Medications: _____
 Both prescription and over the counter

Allergies: _____

Past Surgeries: _____

FAMILY HISTORY

Have Your Parents/Grandparents/Brothers or Sisters had ANY of the following?

	Age	State of Health	Occupation	Age at Death	Cause of Death			Relationship
						Yes	No	
Father					Alcoholism			
Mother					Arthritis			
Brothers					Asthma/Hay Fever			
					Cancer			
					Diabetes			
					Digestive Problems			
					Seizure Disorder/Convulsions			
					Heart Disease			
					High Blood pressure			
Sisters					Kidney Disease			
					Mental Illness			
					Stroke			
					Thyroid Disorder			
					Tuberculosis			

EXPLANATION: _____

NAME: _____

PHYSICAL EXAMINATION

A physical examination is **REQUIRED** for all college athletes.

All other students are strongly encouraged to have a physical exam completed prior to arrival on campus. This allows a trusted family clinician to complete an updated physical exam as well as provide anticipatory counseling on issues related to college life.

Ht. _____ Wt. _____

BP _____ HR _____

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.

 Signature of Physician/Health Care Provider

 Date

Printed Name, Address and Phone Number of Health Care Provider

NOTICE OF PRIVACY PRACTICES

(Enclosed with Health History Form)

By signing below, I acknowledge that I have been provided with a copy of the Notice of Privacy Practices of LoGrasso Hall Health Center, SUNY at Fredonia, Version 1.0, dated September 1, 2003.

 STUDENT'S SIGNATURE

 Date