UTICA COLLEGE

UTICA COLLEGE HEALTH FORM, IMMUNIZATIONS AND PHYSICAL EXAM FOR STUDENTS

Due By: July 15 for Fall Admission, January 10 for Spring Admission

Please check one:
☐ Fall Semester, Year _____
☐ Spring Semester, Year _____
☐ Summer Semester, Year _____

Check fill out all that apply:
☐ Athlete: _____ Sport _____
Major _____

Welcome to Utica College. Information is CONFIDENTIAL; it will not be released without the student's consent, and it will not affect the admission status. All four pages of this packet must be submitted to Utica College-Student Health Center, 1600 Burrstone Road, Utica, New York 13502 via mail *or* Fax to 315.792.3700. *For questions, please call 315-792-3094*.

Attention Athletes: For Student Athletes – physical exam must be dated after April 1 for Fall admission or after August 1 for Spring admission per NCAA. Student-athletes must go to www.ucpioneers.com/athletictraining for requirements.

Health Insurance Requirements:

All full-time students are required to have health insurance.

REQUIRED PERSONAL INFORMATION

Utica College ID # _____ Birth date (MM-DD-YY) ____ –____– _____

Last Name _____ First Name _____ MI ___

Cell Phone _____ Sex ☐ Male ☐ Female

Address _____ City _____ State _____ Zip Code _____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name _____ Relationship _____

Home Telephone Number _____ Business Telephone Number _____

Cell Phone Number _____

AUTHORIZATION TO PROVIDE MEDICAL CARE

I hereby authorize the Student Health Center at Utica College to give medical and minor surgical care to (Student Name) _____ on his/her request and to arrange for such care as necessary in the event of emergencies.

_____ _____

Student Signature (if 18 years or older) *Parent/Guardian Signature (if student under 18 years)*

MANDATORY HEALTH UPDATE FORM

Student Name:	Date of Birth:

☐ Yes ☐ No Do you have any drug allergies? Specify. _____ Reaction: _____

_____

☐ Yes ☐ No Do you have any allergies to insect stings, foods, latex, or others? Specify.

☐ Yes ☐ No Do you have any family history of medically unexplained or cardiac-caused sudden death under the age of 50? Please explain. _____

_____

☐ Yes ☐ No Do you have asthma? Please list medications taken for this condition.

_____

☐ Yes ☐ No Do you have diabetes? Please list medications you are taking for this condition.

_____

☐ Yes ☐ No Do you have hypoglycemia (low blood sugar)? _____

☐ Yes ☐ No Do you have any loss of paired-organ function (eye, kidney, testicle)? _____

☐ Yes ☐ No Have you had a previous concussion or loss of consciousness? Please explain. _____

_____

☐ Yes ☐ No Have you ever fainted (syncope) or had near syncope with exercise? _____

☐ Yes ☐ No Have you ever had symptoms of exercised-induced bronchospasm? _____

☐ Yes ☐ No Have you ever had an incident of heart-related illness? _____

☐ Yes ☐ No Have you had any operations? Is so, please list. _____

_____

☐ Yes ☐ No Have you had any serious illnesses in the past? If so, please explain.

_____

☐ Yes ☐ No Have you been hospitalized in the last five years? If so, please explain.

_____

☐ Yes ☐ No Are you currently being treated for anxiety, depression or any other mental health illness? If so, please explain. _____

_____

Please list all medications that you are currently taking. _____

_____

_____

Student Signature _____ Date ____/___/____

***Note to Athletes**: Your signature above authorizes the release of this information between the Student Health Center and the athletic training staff at Utica College.*

Utica College Student Health Center, 1600 Burrstone Road, Utica, NY 13502 ◆ Phone No.: 315.792.3094 ◆ Fax: 315-792-3700

IMMUNIZATIONS

Submit this form OR immunizations records from your school/personal physician.

Student Name:	Date of Birth:
Utica College ID Number:	

REQUIRED IMMUNIZATIONS OR TITERS

Disease	Vaccine Date (Please list dates MM/DD/YY)	Titer (Attach Lab Results)
Combined as MMR 2 doses	Dose 1____/____/_____ Dose 2____/____/_____	
Measles* (Rubeola) 2 doses	Dose 1____/____/_____ Dose 2____/____/_____	
Rubella* (German Measles) 1 dose	____/____/_____	
Mumps* 1 dose	____/____/_____	

REQUIRED RESPONSE FORM

PLEASE COMPLETE 1 OR 2:

1. **Meningococcal** Two doses scenario1) 1st dose by the age of 11 or 12 with a Booster at age 16 #1___/___/___ #2___/___/____ **OR**
scenario 2)1 st dose between ages 13-15 with Booster between 16-18 #1___/___/___ #2___/___/____ **OR**
scenario 3) 1st dose at age 16 or later with no Booster needed. #1___/___/___

Meningococcal B (Bexsero) Dose #1___/___/___ Dose #2___/___/___

Meningococcal B (Trumenba) Dose #1___/___/___ Dose #2___/___/___ Dose #3___/___/___

2. ☐ 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.

Signature_____ **Date**_____/____/_____

Student Signature (or Parent/Guardian signature if student under 18 years)

PLEASE LIST VACCINE DATES FOR THE FOLLOWING:

VACCINE NAME	DATE	DATE	DATE
Tdap	___ /____/ ____	**or** Td ___ /____/ ____	
Hepatitus A	Dose#1: ___ /____/ ____	Dose #2: ___ /____/ ____	
Hepatitus B (3 Doses)	Dose#1: ____/____/ ____	Dose #2: ___ /____/ ____	Dose #3: ___ /____/ ____
Varicella (Chicken Pox)	Dose#1: ___/____/ ____	Dose#2: ___ /____/ ____	**or** Disease Date ___ /____/ ___
Influenza	Dose#1: __ /____/ ____		

Tuberculin Skin Test (PPD) OR Quantiferon Gold

PPD Date Given: ___ /___ /___	Lot #_____	Exp. Date: ___ /___ /___	
PPD Date Read: ___ /___ /___	Results: _____MM ____	(If Positive) Chest X-Ray Date: ___ /___ /___ Result::_____ **(Please attach CXR Report)**	

Quantiferon Gold

Date of Lab Draw: ___ /___ /___	Results: _____	(If Positive) Chest X-Ray Date: ___ /___ /___ Result::_____ **(Please attach CXR Report)**

Physician's Office Use: I certify the above information is complete and accurate.

Physician Name (Signature): _____ MD, NP, PA, DO	**Date:**
Address:	City/State, Zip Code:
Telephone:	Fax:

MANDATORY PHYSICAL EXAM

Name _____ D.O.B. ____/____/____

Exam: Height _____ **Weight** _____ **B/P** _____ **P** _____ **BMI** _____

√ Check = Normal Circle = N/A Blank = Not Examined	Note Variances, Abnormal or Significant Findings
☐ General: Healthy appearing, in no acute distress	
☐ Skin: Warm, pink, dry with no rash or lesions	
☐ Head/Face: Normocephalic. Normal hair growth	
☐ Eye: Sclera white. PERRLA.	
☐ Nose/Sinuses: Sinuses non-tender to palpation, nares	
☐ Ears: No pain when helix pulled. External canal normal. TM with light reflex and landmarks present without erythema, injection, bulging, fluid, retraction, perforation or drainage. No hearing loss.	
☐ Pharynx: Good dental hygiene. No tonsilar hypertrophy. No erythema, swelling, injection, exudate or lesions of palate/pharynx. Uvula midline.	
☐ Neck: Supple with full ROM. No cervical adenopathy. No thyromegaly.	
☐ Respiratory: Respirations easy and non-labored. Aerates all lobes well. Lungs clear to auscultation and percussion. No pleural rub heard.	
☐ Cardiovascular: Regular S1, S2 without murmur, gallop or run. No peripheral edema.	
☐ Abdomen: Soft, non-distended with active bowel sounds x 4. No hepatosplenomegaly. No abdominal guarding, rigidity, tenderness or masses on palpation. No CVA tenderness.	
☐ Musculoskeletal: Extremities with full ROM, no varicosities.	
☐ Neurologic: Oriented x 3. Cranial nerves II-XII intact.	
☐ Breast: Symmetrical, no masses/lumps, no dimpling, no palpable nodes, no nipple discharge, no retraction, no tenderness, BSE discussed.	
☐ Genitourinary: External genitalia and hair distribution WNL, inguinal nodes WNL, no urethral lesions or tenderness.	

List all current medications _____

☐ Yes ☐ No Any pertinent physical findings (e.g. heart murmur, etc.) Specify _____

☐ Yes ☐ No Any recommendations for limitation of physical activity? Specify _____

☐ Yes ☐ No Is this individual under care for a chronic condition or serious illness? If yes, attach letter of recommendations.

☐ Yes ☐ No Any recommendations for special dietary requirements? Specify _____

☐ Yes ☐ No Any recommendations for special housing considerations? Specify _____

☐ Unrestricted athletic participation ☐ Conditional athletic participation ☐ No participation

☐ List further medical evaluation need before participation is allowed _____

Provider's Signature: _____ MD, NP, PA, DO		**Date:**
Address:	City/State, Zip Code:	
Telephone:	Fax:	

Please mail completed form to: Utica College Student Health Center, 1600 Burrstone Road, Utica, NY 13502 ◆ Phone No.: 315.792.3094 ◆ Fax: 315-792-3700