

Please check one:	Year	Check fill out all that apply:
<input type="checkbox"/> Fall Semester		Athlete: <input type="checkbox"/> Yes or <input type="checkbox"/> No
<input type="checkbox"/> Spring Semester		Sport:
<input type="checkbox"/> Summer Semester		Major:

Welcome to Utica University. Information is **CONFIDENTIAL**; it will not be released without the student's consent. **All four pages of this packet must be submitted to:** Utica University-Student Health Center, 1600 Burrstone Road, Utica, New York 13502. Send by mail, Fax to 315.792.3700 or Register for Student Health Portal at <https://www.utica.edu/student/health/>. **For questions, please call 315-792-3094.**

- **Attention 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. Student athletes must also include proof of sickle cell testing and results per NCAA requirements.
- **Health Insurance Requirements:** All full-time students are required to have health insurance.

Student's Required Personal Information

Utica University ID#:		Birth Date (MM-DD-YY): ____ - ____ - ____	
Last Name:	First Name:	MI:	
Cell Phone:	Sex : <input type="checkbox"/> Male <input type="checkbox"/> Female	Preferred Pronoun: <input type="checkbox"/> He/Him/His <input type="checkbox"/> She/Her/Hers <input type="checkbox"/> They/Them/Theirs	Other: _____
Address:	City:	State:	ZC:

Emergency Contact Information

Name:	Relationship:
Home Telephone Number:	Cell Telephone Number:
Business Telephone Number:	Other Telephone Number:

Authorization To Provide Medical Care & Release Information

All registered students AND parent/guardian of students under 18 years of age MUST sign. I hereby give permission to the Utica University medical/nursing staff to examine and treat (Student's name) _____ for all medical problems/injuries while he/she is at Utica University. In the event of time restraints or that I cannot be reached, I hereby give permission for the Student Health Center Staff to secure consultative care that may include hospitalization, anesthesia, surgery and/or other medical treatment. I also give permission for the Utica University medical/nursing staff to share pertinent health information with the Utica University's Counseling Center and Office of Learning Services staff as deemed necessary. I understand I have the right to revoke this consent at any time.

Athletes: I hereby give permission to both the Utica University Student Health Center and Athletics to share pertinent health information between each other for participation in intercollegiate sports.

Health Professions: I hereby give permission to the Utica University Student Health Center, Department of Nursing, Physical Therapy, Occupational Therapy, Therapeutic Recreation, and Child Life-Psychology to share pertinent health information between each other for clinical activity.

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

Mandatory Health Update Form

Student Name:		Date of Birth:
1.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any drug allergies? Specify:
Reactions:		
2.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any allergies to insect stings, foods, latex, or others?
Specify:		
3.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any family history of medically unexplained or cardiac-caused sudden death under the age of 50?
Explain:		
4.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have asthma? Please list medications taken for this condition.
List Meds:		
5.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have diabetes? Please list medications you are taking for this condition.
List Meds:		
6.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have hypoglycemia (low blood sugar)?
7.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any loss of paired-organ function (eye, kidney, and testicle)?
8.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had a previous concussion or loss of consciousness?
Explain:		
9.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever fainted (syncope) or had near syncope with exercise?
10.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had symptoms of exercised-induced bronchospasm?
11.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had an incident of heart-related illness?
12.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had any operation(s)? If so, please list type(s) and date(s)
List:		
13.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had any serious illnesses in the past? If so, please explain.
Explain:		
14.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been hospitalized in the last five years? If so, please explain.
Explain:		
15.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently being treated for any medical illnesses or mental health issues (ie. anxiety, depression, etc.) If so, please explain.
Explain:		
Please list all medications that you are currently taking:		
1.	4.	
2.	5.	
3.	6.	

Student Signature: _____ **Date:** _____

Submit this form and immunizations from your school/personal physician.

Student Name:		Date of Birth:	
Utica University ID #:			
Required Immunizations or Titers			
Disease	Vaccine Date (Please list dates MM/DD/YY)	Titer (Attach Lab Results)	
Combined as MMR 1 Doses	Dose 1 ___/___/___ Dose 2 ___/___/___		
Measles* (Rubeola) 2 doses	Dose 1 ___/___/___ Dose 2 ___/___/___		
Rubella* (German Measles) 1 dose	Dose 1 ___/___/___		
Mumps* 1 dose	Dose 1 ___/___/___		
Required Response Form (Meningococcal Vaccine)			
Please Complete 1 or 2: Student must have Meningitis (MCV4)/Meningitis B vaccine in the last 5 years.			
1. Meningococcal 2 Doses	Scenario 1: 1 st 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
Meningococcal 1 Dose	Scenario 3: 1 st dose at age 16 or later with no Booster needed.	#1 ___/___/___	
2. <input type="checkbox"/> Check Box to Waive	To waive, I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the Meningitis MCV4/Meningitis B vaccine ; I have decided that I (my child) will not obtain immunization against meningococcal meningitis disease.		
Signature: _____		Date: ___/___/___	
<i>Student Signature (or Parent/Guardian signature if student under 18 years)</i>			
Other Vaccines (Please List Vaccine Dates for the Following)			
Vaccine	1 st Date	2 nd Date	3 rd Date
Hepatitis A	Dose 1 ___/___/___	Dose 2 ___/___/___	
Hepatitis B (3 Doses)	Dose 1 ___/___/___	Dose 2 ___/___/___	Dose 3 ___/___/___
Influenza	Dose 1 ___/___/___		
Meningococcal B (Bexsero)	Dose 1 ___/___/___	Dose 2 ___/___/___	
Meningococcal B (Trumenba)	Dose 1 ___/___/___	Dose 2 ___/___/___	Dose 3 ___/___/___
Tdap	___/___/___	Or Td ___/___/___	
Varicella (Chicken Pox)	Dose 1 ___/___/___	Dose 2 ___/___/___	Or Disease Date ___/___/___
Tuberculin Skin Test (PPD)			
PPD Date Given: ___/___/___	Lot #:	Exp. Date:	
PPD Date Read: ___/___/___	Results: _____ MM: _____	If Positive result, please attach CXR Report. Chest X-Ray Date: ___/___/___ Result: _____	
Quantiferon Gold			
Date of Lab Draw: ___/___/___	Results: _____	If Positive result, please attach CXR Report. Chest X-Ray Date: ___/___/___ Result: _____	
Physician Name (Signature):		Date:	
Address:		City/State, Zip Code:	
Telephone:		Fax:	

Student Name:	Date of Birth:
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EXAM:	Height:	Weight:	B/P:	P:	BMI:
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No.	√ Check = Normal Circle = N/A Blank = Not Examined	Note Variances, Abnormal or Significant Findings
1.	<input type="checkbox"/> General: Healthy appearing, in no acute distress	
2.	<input type="checkbox"/> Skin: Warm, dry with no discoloration, rash or lesions	
3.	<input type="checkbox"/> Head/Face: Normocephalic. Normal hair growth	
4.	<input type="checkbox"/> Eye: Sclera white. PERRLA.	
5.	<input type="checkbox"/> Nose/Sinuses: Sinuses non-tender to palpation, nares	
6.	<input type="checkbox"/> 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.	
7.	<input type="checkbox"/> Pharynx: Good dental hygiene. No tonsillar hypertrophy. No erythema, swelling, injection, exudate or lesions of palate/pharynx. Uvula midline.	
8.	<input type="checkbox"/> Neck: Supple with full ROM. No cervical adenopathy. No thyromegaly.	
9.	<input type="checkbox"/> Respiratory: Respirations easy and non-labored. Aerates all lobes well. Lungs clear to auscultation and percussion. No pleural rub heard.	
10.	<input type="checkbox"/> Cardiovascular: Regular S1, S2 without murmur, gallop or run. No peripheral edema.	
11.	<input type="checkbox"/> Abdomen: Soft, non-distended with active bowel sounds x 4. No hepatosplenomegaly. No abdominal guarding, rigidity, tenderness or masses on palpation. No CVA tenderness.	
12.	<input type="checkbox"/> Musculoskeletal: Extremities with full ROM, no varicosities.	
13.	<input type="checkbox"/> Neurologic: Oriented x3. Cranial nerves II-XII intact.	
14.	<input type="checkbox"/> Breast: Symmetrical, no masses/lumps, no dimpling, no palpable nodes, no nipple discharge, no retraction, no tenderness, BSE discussed.	
15.	<input type="checkbox"/> Genitourinary: External genitalia and hair distribution WNL, inguinal nodes WNL, no urethral lesions or tenderness.	

List all Current Medications			
1.	2.	3.	4.
<input type="checkbox"/> Yes <input type="checkbox"/> No	Any pertinent physical findings (e.g. heart murmur, etc.)	Specify:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Any recommendations for limitation of physical activity?	Specify:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is this individual under care for a chronic condition or serious illness?	If yes, attach letter of recommendations.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Any recommendations for special dietary requirements?	Specify:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Any recommendations for special housing considerations?	Specify:	

IMPORTANT NOTE: Section is required to be completed by the provider.

<input type="checkbox"/> Unrestricted athletic participation	<input type="checkbox"/> Conditional athletic participation	<input type="checkbox"/> No participation
List further medical evaluation need before participation is allowed.		
Provider's Signature		
Physician Name (Signature):		Date:
Address:		City/State, ZC:
Telephone:		Fax: