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:	Year	Check fill out all that apply:
☐ Fall Semester		Athlete: ☐ Yes or ☐ No
☐ Spring Semester		Sport:
☐ Summer Semester		Major:

Welcome to Utica College. Information is **CONFIDENTIAL**; it will not be released without the student's consent. **All four pages of this packet must be submitted to**: Utica College-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.
- **Health Insurance Requirements:** All full-time students are required to have health insurance.

Student's Required Personal Information			
Utica College ID#:	Birth Date (MM-DD-YY): _____-_____ -_____		
Last Name:	First Name:		MI:
Cell Phone:	Sex : ☐ Male ☐ Female		
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 College medical/nursing staff to examine and treat (Student's name) _____ for all medical problems/injuries while he/she is at Utica College. In the event of time restraints or that I cannot be reached, I hereby give permission for the Student Wellness Center Staff to secure consultative care that may include hospitalization, anesthesia, surgery and/or other medical treatment. I also give permission for the Utica College medical/nursing staff to share pertinent health information with the Utica College'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 College Student Wellness 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 College Student Wellness 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.	☐ Yes ☐ No	Do you have any drug allergies? **Specify:**
Reactions:		
2.	☐ Yes ☐ No	Do you have any allergies to insect stings, foods, latex, or others?
Specify:		
3.	☐ Yes ☐ No	Do you have any family history of medically unexplained or cardiac-caused sudden death under the age of 50?
Explain:		
4.	☐ Yes ☐ No	Do you have asthma? Please list medications taken for this condition.
List Meds:		
5.	☐ Yes ☐ No	Do you have diabetes? Please list medications you are taking for this condition.
List Meds:		
6.	☐ Yes ☐ No	Do you have hypoglycemia (low blood sugar)?
7.	☐ Yes ☐ No	Do you have any loss of paired-organ function (eye, kidney, and testicle)?
8.	☐ Yes ☐ No	Have you had a previous concussion or loss of consciousness?
Explain:		
9.	☐ Yes ☐ No	Have you ever fainted (syncope) or had near syncope with exercise?
10.	☐ Yes ☐ No	Have you ever had symptoms of exercised-induced bronchospasm?
11.	☐ Yes ☐ No	Have you ever had an incident of heart-related illness?
12.	☐ Yes ☐ No	Have you had any operation(s)? Is so, please list type(s) and date(s)
List:		
13.	☐ Yes ☐ No	Have you had any serious illnesses in the past? If so, please explain.
Explain:		
14.	☐ Yes ☐ No	Have you been hospitalized in the last five years? If so, please explain.
Explain:		
15.	☐ Yes ☐ 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:** _____

Immunizations

UTICA COLLEGE

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

Student Name:	**Date of Birth:**
Utica College 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: 1st dose by the age of 11 or 12 with a Booster at age 16	#1 ___/___/___	#2 ___/___/___ OR
	Scenario 2: 1st dose between ages 13-15 with Booster between 16-18	#1 ___/___/___	#2 ___/___/___ OR
Meningococcal 1 Dose	Scenario 3: 1st dose at age 16 or later with no Booster needed.	#1 ___/___/___	

2. ☐ **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: ____/____/_____

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

Other Vaccines (Please List Vaccine Dates for the Following)

Vaccine	1st Date	2nd Date	3rd 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:**

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Mandatory Physical Exam

Student Name:	Date of Birth:

EXAM:	Height:	Weight:	B/P:	P:	BMI:

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

List all Current Medications			
1.	**2.**	**3.**	**4.**

☐ 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:**

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

☐ **Unrestricted athletic participation**	☐ **Conditional athletic participation**	☐ **No participation**
List further medical evaluation need before participation is allowed.		

Provider's Signature	
Physician Name (Signature):	**Date:**
Address:	**City/State, ZC:**
Telephone:	**Fax:**