

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 & RELEASE OF 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.

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

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. **Student signature** _____ **Date** _____

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

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? If 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 ____ / ____ / ____

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: MUST HAVE MENINGITIS VACCINE IN THE LAST 5 YEARS

1. **Meningococcal** Two 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**
 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. 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 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 ___/___/___	
Hepatitis A	Dose #1: ___/___/___	Dose #2: ___/___/___	
Hepatitis 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: _____
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
<input type="checkbox"/> General: Healthy appearing, in no acute distress	
<input type="checkbox"/> Skin: Warm, pink, dry with no rash or lesions	
<input type="checkbox"/> Head/Face: Normocephalic. Normal hair growth	
<input type="checkbox"/> Eye: Sclera white. PERRLA.	
<input type="checkbox"/> Nose/Sinuses: Sinuses non-tender to palpation, nares	
<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.	
<input type="checkbox"/> Pharynx: Good dental hygiene. No tonsillar hypertrophy. No erythema, swelling, injection, exudate or lesions of palate/pharynx. Uvula midline.	
<input type="checkbox"/> Neck: Supple with full ROM. No cervical adenopathy. No thyromegaly.	
<input type="checkbox"/> Respiratory: Respirations easy and non-labored. Aerates all lobes well. Lungs clear to auscultation and percussion. No pleural rub heard.	
<input type="checkbox"/> Cardiovascular: Regular S1, S2 without murmur, gallop or run. No peripheral edema.	
<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.	
<input type="checkbox"/> Musculoskeletal: Extremities with full ROM, no varicosities.	
<input type="checkbox"/> Neurologic: Oriented x3. Cranial nerves II-XII intact.	
<input type="checkbox"/> Breast: Symmetrical, no masses/lumps, no dimpling, no palpable nodes, no nipple discharge, no retraction, no tenderness, BSE discussed.	
<input type="checkbox"/> 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: _____
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Address: _____	City/State. Zip Code: _____
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Telephone: _____	Fax: _____	
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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