

PHYSICAL EXAM AND IMMUNIZATION FORM



111 WAVERLY AVENUE
 SYRACUSE, NY 13244
 PHONE (315) 443-9005 FAX (315) 443-9010

Welcome to Syracuse University. Your health history is an important part of the care we will provide to you while you are a student. Please fill out all sections on pages 1 & 2 and then your Health Care Provider needs to complete the Immunization and Physical Exam form on pages 3 & 4. PLEASE BE SURE THAT YOUR NAME IS WRITTEN ON THE TOP OF EACH PAGE (1-4) OF THIS FORM. Thank You.

NAME AND ADDRESS PLEASE PRINT		DATE:	
Last Name, First Name, MI		Social Security Number	
Street Address/PO Box/Apt.#		City	State ZIP
Telephone	Date of Birth	Age	Gender

EMERGENCY CONTACTS (PERSONS TO BE CONTACTED IN CASE OF EMERGENCY) Please list two contacts		
1. Name	Relationship	Home Phone
Address		Business Phone
2. Name	Relationship	Home Phone
Address		Business Phone

PRIMARY CARE PHYSICIAN	Phone
Address	Fax

HEALTH INSURANCE: A copy of your insurance information is *required* for your health record. It would be beneficial for you to have your own card or a copy in your possession while at college.

Please photocopy **FRONT** and **BACK** of your insurance card and attach here

OR

Please check here if you will be purchasing Student Health Insurance thru Syracuse University.

THIS FORM MUST BE COMPLETED AND RETURNED BY JUNE 1ST

STUDENT LAST NAME

FIRST

MI

ATTENTION STUDENTS UNDER EIGHTEEN (18)

In order to procure quickly any emergency care that may be necessary for students and at the same time to protect the physicians and institutions involved, it is required that **you sign** the consent for emergency treatment below.

I _____ do hereby authorize the Medical staff of Syracuse University
PARENT/GUARDIAN PLEASE PRINT NAME

Health Services upon consultation with a practicing physician or surgeon to exercise for me and on my behalf, all rights and duties with reference to consenting to appropriate medical, psychiatric, and surgical treatment, anesthetics, medicines and hospitalization, including care and treatment by any hospital, staff surgeon, physician or radiologist which they may deem necessary for the emergency care of my son/daughter

PRINTED FULL NAME OF STUDENT

STUDENT'S DATE OF BIRTH

PARENT/GUARDIAN SIGNATURE

DATE

To all Students, Parents, and Health Care Providers: Health information submitted to Health Services via this form will be held confidential as part of the student's medical record in accordance with federal laws regarding confidentiality of protected health information.

PLEASE COMPLETE THIS SECTION BEFORE GOING TO YOUR HEALTH CARE PROVIDER FOR EXAMINATION (please print).

PERSONAL MEDICAL HISTORY

HAVE YOU HAD?	Yes		Yes		Yes	FAMILY MEDICAL HISTORY	Yes	Relationship
Measles		Head Injury w/ concussion		Crohn's/Ulcerative Colitis		Diabetes		
German Measles		Surgery: explain below		Hernia		Kidney Disease		
Mumps		Seizures		Acne (on medication)		Heart Disease		
Malaria		Weakness/Paralysis		Urinary Tract Infection		High blood pressure		
Tuberculosis		Shortness of Breath		Kidney Disease		Cancer		
Mononucleosis		Allergies		Diabetes		Epilepsy/Seizures		
Eye Trouble		Asthma		Thyroid Disorder		Other		
Ear Infections		Palpitations (Heart)		High Cholesterol				
Throat Infections		High Blood Pressure		Disease/Injury of Joints				
ADD/ADHD		Heart Murmur		Back Problems				
Insomnia		Rheumatic Fever		Tumor/Cancer (explain below)				
Anxiety/Depression		Hepatitis		Recent Weight Gain or Loss				
Psychotherapy		Stomach or Intestinal Trouble		FEMALES ONLY:				
Fainting Spells		Gallbladder		Irregular Periods				
Migraines		Recurrent Diarrhea		Birth Control (list below)				

PLEASE EXPLAIN ANY "YES" ANSWERS ABOVE:

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REQUIRED IMMUNIZATIONS BY NEW YORK STATE
Students with incomplete immunization records will NOT be able to obtain grades and will be ineligible to register for a second semester.

MMR	First Dose	Second Dose
<i>Measles, Mumps, Rubella</i>	_____	_____
	mo/da/yr	mo/da/yr

IF BORN AFTER 1956, TWO DOSES OF LIVE VIRUS MEASLES VACCINE, OR MMR, THE FIRST DOSE AT 12 MONTHS OF AGE OR LATER AND THE SECOND DOSE AT LEAST ONE MONTH LATER. PERSONS BORN BEFORE 1957 ARE EXEMPT DUE TO NATURAL IMMUNITY FROM THE DISEASE.

OR
2 doses **Measles** 1st _____ 2nd _____ 1 dose **Mumps** _____ 1 dose **Rubella** _____
month/day/yr month/day/yr month/day/yr month/day/yr

OR
Serologic evidence (blood work) of immunity to each. **Lab work must be submitted with physical.**

MENINGOCOCCOL MENINGITIS VACCINE RESPONSE BELOW

MENINGOCOCCAL MENINGITIS _____ Student received the meningococcal meningitis vaccine.
OR month/day/year

MENINGOCOCCAL MENINGITIS WAIVER REQUIRED IF DOCUMENTATION OF VACCINATION NOT PROVIDED

Waiver: I have reviewed the enclosed Fact Sheet regarding meningococcal disease. I am fully aware of the risks associated with this disease and of the availability and effectiveness of the vaccine. I have elected NOT to get the vaccine.

Signature of Student (or parent/guardian if under 18)

_____ Date _____

RECOMMENDED IMMUNIZATIONS

PPD (Mantoux) within 6 months of admission to college _____ mm induration
Date Administered Date Interpreted Result

If currently history of positive PPD, chest x-ray report (in ENGLISH and done within 6 months of admission), with date and result must be submitted with physical.

International Students must all have tuberculosis screening done at Syracuse University Health Services upon arrival to campus.

TETANUS (Td) Within 10 years of admission to college _____
month/day/yr

HEPATITIS B #1 _____ **OR** #2 _____ #3 _____

HEPATITIS A #1 _____ **OR** #2 _____

VARICELLA ___history of chicken-pox disease please check **OR** #1 _____ #2 _____

OR Titer (include lab report): pos neg

COLLEGE USE ONLY	
Reviewed by	Date entered
Fall 20__	Spring 20__

SIGNATURE/MEDICAL PROFESSIONAL CERTIFYING ABOVE IMMUNIZATION RECORD

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STUDENT LAST NAME

FIRST

MI

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PHYSICAL EXAMINATION

Date of Exam: _____ (Must be completed not more than one year prior to the start of the semester).

Ht. _____ Wt. _____ BP _____ Pulse _____ Build: Slender Med. Heavy Obese

CLINICAL EXAMINATION

Check each item in proper column; Enter NE if not evaluated.	Normal	Abnormal	If abnormalities are noted, please describe
Neck			
HEENT			
Lungs, chest and breasts			
Heart (include any murmur/defect)			
Abdomen (include hernia)			
Genitalia			
Musculoskeletal/Extremities			
Skin			
Neurologic			
Psychiatric			

Does this student have any limitations while attending Syracuse University? Yes No **If YES, what activities are to be limited?**

ALLERGY TO: (Please circle Yes or No)

Medication No Yes (Please list) _____

Insect bites/bee stings No Yes _____

Foods No Yes (Please list) _____

Other Yes Please explain _____

Does patient need to carry an Epi-pen? Yes No

CURRENT MEDICATIONS: Please list any prescription and over the counter medications, including birth control pills:

Name Dose How taken

None

Name of examining Physician/NP/PA			Date
Street	City	State	Zip code
Signature		Area code and phone #	
Student, Please return completed form to: Syracuse University Health Services 111 Waverly Avenue Syracuse, NY 13244 Phone (315) 443-9005 Fax (315) 443-9010			

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