Incoming Student Mandatory
Health History, Physical, and Immunizations Form
Fall Semester Due: July 15  Spring Semester Due: January 1

NEW STUDENT INFORMATION – PLEASE PRINT

<table>
<thead>
<tr>
<th>Student Name (Last, first, middle initial)</th>
<th>Sex</th>
<th>Date of Birth</th>
<th>Student ID Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Home Address</th>
<th>City/State</th>
<th>Zip</th>
<th>Cell Phone Number</th>
</tr>
</thead>
</table>

Please Check Class Year/Level:
- [ ] Freshman
- [ ] Transfer (Soph, Junior, Senior)
- [ ] Graduate

Check One:
- [ ] Fall Semester: Year _________
- [ ] Spring Semester: Year _________
- [ ] Summer Semester: Year _________

Please Check:
- [ ] Resident
- [ ] Commuter

Commuter Address

Emergency Contact Name

Relationship

Telephone No.

Name and phone number of Primary Care Provider:

INSURANCE INFORMATION – PLEASE PRINT

<table>
<thead>
<tr>
<th>Insurance Company Name</th>
<th>Subscriber’s Name</th>
</tr>
</thead>
</table>

Relationship of Patient to Insured (check one):
- [ ] Self
- [ ] Spouse
- [ ] Child
- [ ] Other

Subscriber ID

Suffix (if any)

Please provide a copy of your health insurance card with this form.

Charges will be filed with your insurance company by our billing service.

Authorization to provide medical care: I hereby authorize the St. John Fisher College Health and Wellness Center to provide medical and/or minor surgical care and to arrange for such care as necessary in the event of emergencies.

Authorization to bill insurance: I authorize St. John Fisher College to furnish medical claim information to my insurance carrier. I understand that my insurance company will remit payment directly to St. John Fisher College for medical services rendered to me. I understand that I am responsible for any charges that I incur by choosing to utilize the services of the Health and Wellness Center.

Athletes: My signature authorizes release of this information between the Health and Wellness Center and the athletic training staff at St. John Fisher College.

Student Signature: ___________________________ Date: ____________

If you are under 18, parent/guardian signature is required below:

Parent/Guardian Signature: ___________________________ Date: ____________

Healthy Student Checklist

<table>
<thead>
<tr>
<th>Did you submit?</th>
<th>Did you submit?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Health History Form</td>
<td>☐ Health History Form</td>
</tr>
<tr>
<td>☐ Immunization Record</td>
<td>☐ Copied Insurance Card</td>
</tr>
<tr>
<td>☐ Meningitis Response Form</td>
<td>☐ Completed Physical</td>
</tr>
</tbody>
</table>

Questions about this form? Phone: (585) 385-8280 Email: healthcenter@sfc.edu

April 2016
**STUDENT: Complete your Health History**

**Medical or Health Concerns**- Please mark any disease/conditions you have had.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS or HIV Infection</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Anemia</td>
<td>Depression</td>
</tr>
<tr>
<td>Anorexia/Bulimia</td>
<td>Digestive Problems</td>
</tr>
<tr>
<td>Anxiety/Panic Disorder</td>
<td>Dizziness/Fainting</td>
</tr>
<tr>
<td>Arthritis</td>
<td>Drug/Alcohol Problem</td>
</tr>
<tr>
<td>Asthma</td>
<td>Epilepsy/Seizures</td>
</tr>
<tr>
<td>Autoimmune Disease</td>
<td>Fractures</td>
</tr>
<tr>
<td>Bleeding Disorder</td>
<td>Gallbladder Disease</td>
</tr>
<tr>
<td>Blood Disorder</td>
<td>Glaucoma</td>
</tr>
<tr>
<td>Cancer/Tumor/Cyst</td>
<td>Gum or Tooth Trouble</td>
</tr>
<tr>
<td>Cerebral Palsy</td>
<td>Head Injury/Concussion</td>
</tr>
<tr>
<td>Chronic Cough</td>
<td>Heart Disease</td>
</tr>
<tr>
<td>Other</td>
<td>No</td>
</tr>
</tbody>
</table>

Please comment on all YES answers:

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**Do you have any allergies to:**

- Latex: No Yes Explain Yes:  
- Medications: No Yes Explain Yes:  
- Other: No Yes Explain Yes:  

**What medicines do you take regularly?** (Attach separate list if more room needed.)

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose/Quantity</th>
<th>How often?</th>
<th>Reason</th>
</tr>
</thead>
</table>

---

**Family History:** Have any of your family members had the following?

Please indicate whom using this code: M=Mother, F=Father, S=Sibling (brother or sister) or GP=Grandparent

<table>
<thead>
<tr>
<th>Disease</th>
<th>Who?</th>
<th>Who?</th>
<th>Who?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Clots</td>
<td>Glaucoma</td>
<td>Mental Illness</td>
<td></td>
</tr>
<tr>
<td>Bleeding Disorder</td>
<td>Headache Disorder</td>
<td>Sickle Cell Anemia</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td>Heart Disease</td>
<td>Stroke</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>High Blood Pressure</td>
<td>Other (specify)</td>
<td></td>
</tr>
</tbody>
</table>

Please comment on all YES answers:

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*Return completed forms to: Health and Wellness Center, St. John Fisher College*

*Mail: 3690 East Avenue, Rochester, NY 14618 or Fax: (585) 385-8299*

*Questions about this form? Phone: (585) 385-8280 Email: healthcenter@sjfc.edu*

*April 2016*
NYS Public Health Law Immunization Requirements

Submit this form with immunization records from your health care provider/school health record

<table>
<thead>
<tr>
<th>Name:</th>
<th>Student ID#: @</th>
<th>DOB:</th>
</tr>
</thead>
</table>

**STUDENT: NYS REQUIRED Meningitis Response Form - Check and Sign ONLY ONE Box.**

- **Received the meningococcal meningitis immunization (Menactra/Menomune/Menveo) within the past 10 years.**
  - Date(s) received: ___________ ___________
  - Signature of student (or parent/guardian for students under the age of 18) Date

- **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 will not obtain immunization against meningococcal meningitis disease.**
  - Signature of student (or parent/guardian for students under the age of 18) Date

**HEALTH CARE PROVIDER: Complete immunization information below and attach entire immunization record.**

<table>
<thead>
<tr>
<th>MMR Vaccination Dates</th>
<th>Meningococcal Meningitis Vaccination Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New York State REQUIRES students demonstrate immunity to measles, mumps and rubella</strong></td>
<td><strong>Recommended for all students</strong></td>
</tr>
<tr>
<td>Date: Date:</td>
<td>Date: Date:</td>
</tr>
</tbody>
</table>

**OR IF GIVEN AS INDIVIDUAL VACCINATIONS:**

<table>
<thead>
<tr>
<th>Measles (Rubeola), 2 doses</th>
<th>Date: Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rubella (German Measles), 1 dose</td>
<td>Date: Date:</td>
</tr>
<tr>
<td>Mumps, 1 dose</td>
<td>Date:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OR TITER RESULTS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date: ___________ Positive OR Negative</td>
</tr>
<tr>
<td>Date: ___________ Positive OR Negative</td>
</tr>
<tr>
<td>Date: ___________ Positive OR Negative</td>
</tr>
</tbody>
</table>

I certify that the above is complete and accurate.

Provider Name: ___________________________________________ MD NP PA

Print or Stamp Signature

Address: ___________________________ City/State/Zip ___________________________

Date form completed: ___________________________ Phone (___) ______________________

Fax to: 585-385-8299 OR mail to: Health and Wellness Center, St. John Fisher College, 3690 East Ave, Rochester, NY 14618

Questions about this form? Phone: (585) 385-8280 Email: healthcenter@sjfc.edu

April 2016
What is meningococcal disease?
Meningococcal disease is a severe bacterial infection of the bloodstream or meninges (a thin lining covering the brain and spinal cord) caused by the meningococcus germ.

Who gets meningococcal disease?
Anyone can get meningococcal disease, but it is more common in infants and children. For some adolescents, such as first-year college students living in dormitories, there is an increased risk of meningococcal disease. Every year in the United States approximately 2,500 people are infected and 300 die from the disease. Other persons at increased risk include household contacts of a person known to have had this disease, immunocompromised people, and people traveling to parts of the world where meningococcal meningitis is prevalent.

How is the meningococcus germ spread?
The meningococcus germ is spread by direct close contact with nose or throat discharges of an infected person.

What are the symptoms?
High fever, headache, vomiting, stiff neck and a rash are symptoms of meningococcal disease. The symptoms may appear two to 10 days after exposure, but usually within five days. Among people who develop meningococcal disease, 10 to 15 percent die, in spite of treatment with antibiotics. Of those who live, permanent brain damage, hearing loss, kidney failure, loss of arms or legs, or chronic nervous system problems can occur.

What is the treatment for meningococcal disease?
Antibiotics, such as penicillin G or ceftriaxone, can be used to treat people with meningococcal disease.

Should people who have been in contact with a diagnosed case of meningococcal meningitis be treated?
Only people who have been in close contact (household members, intimate contacts, health care personnel performing mouth-to-mouth resuscitation, daycare center playmates, etc.) need to be considered for preventive treatment. Such people are usually advised to obtain a prescription for a special antibiotic (either rifampin, ciprofloxacin or ceftriaxone) from their physician. Casual contact, as might occur in a regular classroom, office or factory setting, is not usually significant enough to cause concern.

Is there a vaccine to prevent meningococcal meningitis?
There are three vaccines available for the prevention of meningitis. The preferred vaccine for people ages 2-55 years is Meningococcal conjugate vaccine (MCV4). This vaccine is licensed as Menactra (sanofi pasteur) and Menveo (Novartis). Meningococcal polysaccharide vaccine (MPSV4; Menomune [sanofi pasteur]), should be used for adults ages 56 and older. The vaccines are 85 to 100 percent effective in preventing the four kinds of meningococcus germ (types A, C, Y, W-135). These four types cause about 70 percent of the disease in the United States. Because the vaccines do not include type B, which accounts for about one-third of cases in adolescents, they do not prevent all cases of meningococcal disease.

Is the vaccine safe? Are there adverse side effects to the vaccine?
The three vaccines available to prevent meningococcal meningitis are safe and effective. However, the vaccines may cause mild and infrequent side effects, such as redness and pain at the injection site lasting up to two days.

Who should get the meningococcal vaccine?
The vaccine is routinely recommended for all adolescents ages 11-12 years, all unvaccinated adolescents 13-18 years, and persons 19-21 years who are enrolling in college. The vaccine is also recommended for people ages 2 years and older who have had their spleen removed or have other chronic illnesses, as well as some laboratory workers and travelers to endemic areas of the world.

Who needs a booster dose of meningococcal vaccine?
CDC recommends that children age 11 or 12 years be routinely vaccinated with Menactra or Menveo and receive a booster dose at age 16 years. Adolescents who receive the first dose at age 13-15 years should receive a one-time booster dose, preferably at ages 16-18 years. Teens who receive their first dose of meningococcal conjugate vaccine at or after age 16 years do not need a booster dose, as long as they have no risk factors.

All people who remain at highest risk for meningococcal infection should receive additional booster doses. If the person is age 56 years or older, they should receive Menomune.

How do I get more information about meningococcal disease and vaccination?

Source: http://www.health.state.ny.us/diseases/communicable/meningococcal/fact_sheet.htm, Last Reviewed: July 2011
Mandatory Physical Examination for New Students
To be completed by HEALTH CARE PROVIDER
Physical must be completed during the 12 months prior to entry.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Check = Normal</td>
<td>Circle = N/A</td>
<td>Blank = Not Examined</td>
<td>Note Variances, Abnormal or Significant Findings</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **General**: Healthy appearing, in no acute distress.
- **Skin**: Warm, pink, dry with no rash or lesions.
- **Head/Face**: Normcephalic. Normal hair growth.
- **Eye**: Sclera white. PERRLA. EOMI.
- **Nose/Sinuses**: Sinuses nontender 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 nonlabored. Aerates all lobes well. Lungs clear to auscultation and percussion. No pleural rub heard.
- **Cardiovascular**: Regular S1, S2 without murmur, gallop or rub. No peripheral edema.
- **Abdomen**: Soft, nondistended 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.
- **Genitourinary**: External genitalia and hair distribution WNL, inguinal nodes WNL, no urethral lesions or tenderness.
- **Psychiatric**: Specify disorder.

List all medication allergies:
________________________________________________________________________________
________________________________________________________________________________

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: ____________________________________________________________

MANDATORY RESPONSE FOR STUDENT ATHLETES/SPORTS PHYSICALS
THIS SECTION MUST BE COMPLETED FOR ATHLETIC CLEARANCE.

- Unrestricted athletic participation  No participation
- Conditional athletic participation  List further medical evaluation needed before participation allowed

Provider Name: ________________________________  MD NP PA
Print or Stamp ____________________________________________________________________________
Signature __________________________________________________________________________________
Address: ________________________________________________________________________________  City/State/Zip ________________________________
Date form completed: ___________________________  Phone (______) ______________________________

Fax to: 585-385-8299 OR mail to: Health and Wellness Center, St. John Fisher College, 3690 East Ave, Rochester, NY 14618