



SUNY College of Technology

10 Upper College Drive
Alfred, New York 14802

HEALTH SERVICES
Alfred, New York 14802
(607) 587-4200
FAX: (607) 587-4203

Wellsville, New York 14895
(607) 587-3141
FAX: (607) 587-3198

MEDICAL HISTORY IMMUNIZATION RECORD AND PHYSICAL EXAMINATION

Dear Student:

My congratulations to you on your acceptance into Alfred State College.

Included in this packet you will find the required health form to be completed by you and your physician. Please have this completed and sent back to the Health Center by June 30 if you are beginning in the fall semester and Dec. 31 if you are beginning in the spring semester. If you are accepted after this date, please return the form prior to the first day of classes. Failure to return a completed health form may result in denial of pre-registration, withholding of transcripts, inability to receive non-emergent health care, and possible class suspension.

I hope that your experience at Alfred State College will be a happy and healthy one. We are here to help you.

Sincerely,

A handwritten signature in cursive script that reads "Judi Grant".

Judi Grant, R.N., C.S., A.M.N.P.
Director of Health Services

NYS Public Health Laws #2165 and 2167 require specific immunizations as detailed on the physical exam form and on the meningitis information response form on the next page. Students who do not comply will be suspended as dictated by the wording of the law.

RETURN TO: HEALTH CENTER
TA Parish Hall
Alfred State College
10 Upper College Drive
Alfred, New York 14802



Accredited by

Accreditation Association for Ambulatory Health Care, Inc.

MENINGITIS INFORMATION RESPONSE FORM

NYS Public Health Law requires that all college and university students enrolled for at least six (6) semester hours or the equivalent per semester, or at least four (4) semester hours per quarter, receive information on meningitis, the meningitis vaccine (enclosed information sheet), and **complete the following:**

Check one box and sign below:

I have:

had the meningococcal meningitis immunization within the past 10 years.

Date immunized _____ Menomune or Menactra (circle one)

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.

Student's signature _____ Date _____

Parent's/Guardian's signature (only if student is under 18) _____ Date _____

Please note that according to NYS Public Health Law, no institution shall permit any student to attend the institution in excess of 30 days without complying with this law.

FOR PARENTS/GUARDIANS OF APPLICANTS UNDER 18 YEARS OF AGE:

In order to provide health care quickly and efficiently for your student, it is required that you sign and **have notarized** the consent for treatment. For your information, if your student should require emergency treatment at the local hospital, that facility will notify you and request further consent.

I, _____, pursuant to the authority vested in me as _____

— Parent or Guardian Name Parent or Guardian

of _____ do hereby authorize the medical staff of Alfred State College

Student's Full Name

to provide medical treatment for any visits to the Health Services made by my son/daughter. This also authorizes the College physician to become the attending physician for the student in case of hospitalization.

Notary Public
(with seal)

Signature of Parent or Guardian

Subscribed before me this _____ day

of _____
Month Year

**HEALTH CENTER
STATE UNIVERSITY OF NEW YORK COLLEGE OF TECHNOLOGY
WELLSVILLE, NEW YORK 14895
(607) 587-3141**

HEALTH HISTORY

FOR THE STUDENT: You will not be permitted to register for ensuing semesters or receive health care until this completed form (three pages) is received by the Health Center.

You and your parents complete this side Parts A, B, and C before seeing your physician, who completes the reverse side.
All information is held strictly confidential by your Health Center and will not influence your standing at the College.

A. _____, _____, _____, ____/____/____, _____
Last Name First Middle Date of Birth Age

_____ Home Address (Street & No.) _____ City/Town _____ State _____ Zip Code

Student's Cell Phone: _____ Student's Home Phone: _____

Social Security Number _____ - _____ - _____ Have you ever attended Alfred State College? (circle one) Yes No

In case of emergency, the Health Center will notify:

_____, _____, Business Phone: (_____) _____
(Relationship) (Area Code)

Religious Preference (Optional) _____ Home Phone: (_____) _____
(Area Code)

- B. No Yes 1. Do you require any special housing arrangements or medical supervision?
 No Yes 2. Has your physical activity been restricted during the last five years?
 No Yes 3. Are you currently taking any medication regularly?
 No Yes 4. Have you ever received treatment or counseling for a nervous condition or emotional problem?
 No Yes 5. Have you any questions you would like to discuss with a member of Health Services?
 No Yes 6. Do you smoke?
 No Yes 7. Do you use alcohol?

8. Have you ever had:

Allergy to Any Medications	No	Yes	Yellow Jaundice (Hepatitis)	No	Yes
Seizures (convulsions)	No	Yes	Kidney Trouble	No	Yes
Hayfever or Asthma	No	Yes	Mononucleosis	No	Yes
Rheumatic Fever	No	Yes	Chickenpox or Vaccine	No	Yes
Heart Murmur or Condition	No	Yes	Eating Disorder	No	Yes
High Blood Pressure	No	Yes	Alcohol or Other Drug Abuse	No	Yes
Rupture (Hernia)	No	Yes	Surgery	No	Yes
Joint Disease or Injury	No	Yes	Head Injury	No	Yes
Diabetes	No	Yes			

Use the blank space below to give details of all "Yes" responses.

Student Signature _____ Date _____

C. HEALTH INSURANCE: It is important that the student be covered by some form of health insurance or by the College's optional insurance. This is to confirm that the student is covered during the academic year by the following health insurance policy. **(Include a photocopy, front and back, of insurance card.)**

1. Name of policy holder: _____ 2. Policy # _____
 (as written on Identification Card)
 3. Name of Insurance Company: _____ 4. Group # _____ 5. Sequence # _____
 Address of Insurance Company: _____

<p>TO BE COMPLETED BY HEALTH SCIENCE STUDENTS and/or INTERCOLLEGIATE ATHLETES: (Nursing, Health Information Technology-Medical Records, Veterinary Technology) In order to maintain the health and safety of their clients and meet state health laws, agencies used for clinical experience require selected information from the student's health record.</p> <p>In order for intercollegiate athletes to meet eligibility requirements and provide athletics training services in conjunction with your health care, athletes must sign this consent for release of medical information from the Health Services to the Athletics Department.</p> <p>Permission is hereby granted SUNY Alfred to release required information to above said agencies.</p> <p>Student Signature _____ Date _____</p>	<p>Check ALL that apply:</p> <p><input type="checkbox"/> Athlete</p> <p><input type="checkbox"/> Nursing student</p> <p><input type="checkbox"/> HIT-Med. Records student</p> <p><input type="checkbox"/> Veterinary Tech. student</p>
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HEALTH CENTER
STATE UNIVERSITY OF NEW YORK – COLLEGE OF TECHNOLOGY
WELLSVILLE, NEW YORK 14895

FOR THE PHYSICIAN: THE STUDENT WILL NOT BE PERMITTED TO REGISTER FOR ENSUING SEMESTERS UNTIL THIS FORM IS RECEIVED BY THE HEALTH CENTER AT THE ABOVE ADDRESS. ALL INFORMATION YOU PROVIDE WILL BE HELD STRICTLY CONFIDENTIAL AND WILL NOT INFLUENCE THE STUDENT'S ACADEMIC STANDING AT THE COLLEGE. **NOTE: ALL IMMUNIZATIONS AND MRF (MENINGITIS RESPONSE FORM) MUST BE COMPLETED BEFORE FORM CAN BE ACCEPTED. MEASLES, MUMPS, AND RUBELLA IMMUNIZATIONS NOT REQUIRED FOR STUDENTS BORN BEFORE 1/1/57 UNLESS IN NURSING PROGRAM. PHYSICAL EXAM MUST HAVE BEEN COMPLETED WITHIN THE LAST SIX MONTHS.**

HEALTH EVALUATION

DATE: _____ DOB: _____
 NAME: _____ SEX: _____
 HGT: _____ WGT: _____
 B/P: _____ PULSE: _____
 ALLERGIES: _____
 MEDICATIONS: _____
 CURRENT DIAGNOSIS: _____

MANDATORY:
Mantoux Date: _____ Result in MM _____
 (must be done in last 6 months) TineTest not acceptable
 Chest x-ray if positive Date: _____ Result: _____
 Was medication initiated for positive mantoux? _____
Vision: Snellen ___ NO LENSES ___ LENSES ___ FORGOT LENSES
 R: 20/ _____ L: 20/ _____

**IMMUNIZATIONS Required by Public Health Law 2165:
 MUST BE GIVEN AFTER Jan. 1, 1969, ON OR AFTER THE FIRST BIRTHDAY**

Measles (Rubeola) 2 doses:
 1st ___/___/___ MMR Yes No (please circle)
 Mo Day Yr
 2nd ___/___/___ MMR Yes No (please circle)
 Mo Day Yr

Rubella ___/___/___ **Mumps** ___/___/___
 Mo Day Yr Mo Day Yr

A titer proving immunity for each of the above is an acceptable alternative to receiving the immunizations. A copy of the results is required. Please attach to this form.

Tetanus or DT within last seven years Date: _____

LABORATORY DATA (required):
Urinalysis: SG _____ Protein _____ Sugar _____

STRONGLY RECOMMENDED:
HEPATITIS B VACCINE given as follows:
 Dose #1 _____ Dose #2 _____ Dose #3 _____
MENOMUNE VACCINE Date: _____ } (student sign form
MENACTRA VACCINE Date: _____ } on page 2)

**VETERINARY TECHNOLOGY STUDENTS –
 RABIES SERIES GIVEN AS FOLLOWS:**
 Dose #1 _____ Dose #2 _____ Dose #3 _____
Contact your department faculty for further details.

PHYSICAL EXAM	NORMAL	ABNORMAL	EXPLANATION
1. EYES			
2. EARS, NOSE, THROAT			
3. HEARING			
4. MOUTH/TEETH			
5. CARDIOVASCULAR			
6. CHEST/LUNGS			
7. ABDOMEN			
8. GENITOURINARY			
9. MUSCULOSKELETAL			
10. METABOLIC ENDOCRINE			
11. NEUROPSYCH			
12. SKIN			
13. LYMPHATIC			

PLEASE COMMENT IF ANSWERING YES TO ANY OF THE FOLLOWING QUESTIONS:
 Are there any restrictions of physical activity indicated by your exam? ___Yes ___No
 Please detail YES response. _____
 Is the student now under treatment for any medical or emotional problem? ___Yes ___No
 Please detail YES response. _____

 Do you have any recommendations regarding the care of this student? ___Yes ___No
 Please detail YES response. _____

I have examined the above-named student and it is my professional opinion that the student is physically and psychologically able, except as noted above, to undertake college studies.

 Signature MD/NP/PA Examining Practitioner's Name (please print) Phone Number – include area code Date

Address – Street and Number _____, _____, _____ State _____ Zip Code _____