

Plattsburgh

STATE UNIVERSITY OF NEW YORK

HEALTH REPORT

FOR THE CENTER FOR STUDENT HEALTH
AND PSYCHOLOGICAL SERVICES

Confidential Report

Before registering for classes, SUNY Plattsburgh requires that all students are a) appropriately immunized, b) receive a physical examination from a doctor, and c) complete this report and forward it to the Center for Student Health and Psychological Services. In order to comply with these requirements, please complete the initial sections of this report and schedule an appointment with your doctor. During this appointment, your doctor must summarize your immunization record, perform any required immunizations, conduct a physical examination, and complete the Immunization Record and Physical Examination sections of this report. This report must be signed by your doctor and returned to the Center for Student Health and Psychological Services (see address on last page). The Center for Student Health and Psychological Services must receive this report **by July 15** for students who start in the Fall Semester or **by December 15** for students who start in the Spring Semester. All information in this report is confidential and only accessible to the staff of the Center for Student Health and Psychological Services.

Please print or type all information. If you have any questions or need assistance, please contact Linda Dragon at 518-564-2187 (email: linda.dragon@plattsburgh.edu).

STUDENT INFORMATION (TO BE COMPLETED BY THE STUDENT)

1. Name (Family Name, Given Name): _____
2. Home Address: _____
Street City State ZIP
3. Date of Birth (Month/Day/Year): ____/____/____
4. Sex: M F (circle one)
5. Date of Enrollment (Month/Year): ____/____

PERSON TO NOTIFY IN CASE OF AN EMERGENCY (TO BE COMPLETED BY THE STUDENT)

1. Name (Family Name, Given Name): _____
2. Relationship to You: Parent or Legal Guardian (circle one)
3. Home Address: _____
Street City State ZIP
4. Home Phone Number: (____) ____ - ____
5. Work Phone Number: (____) ____ - ____

HEALTH INSURANCE (TO BE COMPLETED BY THE STUDENT)

SUNY Plattsburgh requires that all full-time students enroll in the Student Accident and Sickness Insurance Plan or be covered by comparable and adequate insurance through another source (ex. parent's or spouse's health insurance). Students that are covered by managed care plans outside of Plattsburgh are recommended to investigate the out-of-network benefits of the plan. If these out-of-network benefits significantly restrict the use of health care services in Plattsburgh, we recommend that the student also purchase Student Accident and Sickness Insurance in addition to the managed care plan. Students have the opportunity to accept or decline Student Accident and Sickness Insurance when they receive a bill for each semester. For a detailed description of the benefits and fees related to Student Accident and Sickness Insurance, please reference the separate brochure.

Please indicate whether you are covered by comparable insurance, will enroll in Student Accident and Sickness Insurance, or will have coverage from both by checking the appropriate box below:

- I will enroll in the Student Accident and Sickness Insurance Plan.
- I am covered by comparable insurance (please attach a photocopy of your insurance card).
- I will enroll in the Student Accident and Sickness Insurance Plan and am covered by comparable insurance (please attach a photocopy of your insurance card).

Attach a photocopy of **both sides** of your insurance card here

IMMUNIZATION RECORD

(to be completed by a health care provider)

The State of New York and SUNY Plattsburgh require that all students are immunized against measles (rubeola), mumps, and rubella; polio and tetanus/diphtheria immunizations are recommended but not required. Students are also recommended to be screened for tuberculosis with a PPD (mantoux). Please summarize the student's immunization record by answering the questions below. If you have any questions or need assistance, please contact Linda Dragon at 518-564-2187 (email: linda.dragon@plattsburgh.edu).

Record the Date of Each Dose

	1st Dose	2nd Dose	3rd Dose	4th Dose	5th Dose
1. MMR (required) (Two doses required.) Skip to #5 if complete.					
2. Rubeola (required in absence of MMR) (Two doses required.) Proof of the disease or immune titer is acceptable in lieu of the vaccine. Please record date of the disease or attach a copy of the immune titer report.					
3. Mumps (required in absence of MMR) (One dose required.) Proof of the disease or immune titer is acceptable in lieu of the vaccine. Please record date of the disease or attach a copy of the immune titer report.					
4. Rubella (required in absence of MMR) (One dose required.) Proof of immune titer is acceptable in lieu of the vaccine. Please attach a copy of the immune titer report.					
5. Polio Booster					
6. Tetanus/Diphtheria Must be within 10 years of the student's enrollment date.					
7. Tdap (Last dose.)					
8. Gardasil (3 doses.)					
9. TST (recommended within six months of the physical) An x-ray is required if the tst is positive.	Date tst Administered	Date tst Interpreted	Result (circle one) Positive Negative	X-ray Date	X-ray Result (circle one) Positive Negative
10. Varicella Disease or VARIVAX (Two doses.) Proof of the disease or immune titer is acceptable in lieu of the vaccine. Please record date of the disease or attach a copy of the immune titer report.	1st Shot	2nd Shot	Disease	Titer	
11. Hepatitis B Vaccine (recommended but not required) (Two dose series.)					
12. Hepatitis B Vaccine (recommended but not required) (Three dose series.)					
13. Hepatitis A Vaccine (Two doses.)					
14. Meningococcal (One dose.) Student Signature if declined _____					

15. Student Name: _____ 16. Date of Birth (Month/Day/Year): ____/____/____

17. Provider Signature and Address:

Name of Provider: _____

Provider Address: _____

MEDICAL HISTORY

(to be completed by the student)

Student Name: _____

Date of Birth: ____/____/____
Month Day Year

1. Have you ever been or are you now being treated for any of the following (check appropriate box)?

- | | | |
|--|---|---|
| <input type="checkbox"/> Abnormal PAP smear | <input type="checkbox"/> Cystitis or urinary infections | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Alcohol/substance abuse | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Infectious mononucleosis |
| <input type="checkbox"/> Allergies/hay fever | <input type="checkbox"/> Disorders of eye, ear, nose, or throat | <input type="checkbox"/> Inflammatory bowel syndrome |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Depression/anxiety | <input type="checkbox"/> Injury to legs, feet, arms, or hands |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gynecological disorders | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Head injury/concussion | <input type="checkbox"/> Loss of consciousness |
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Heart disease/murmur | <input type="checkbox"/> Migraine headaches |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Sexually transmitted infections |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Hernia | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Convulsions/seizures | | |

2. Explain any positive responses to the question above. _____

3. Have you ever been hospitalized or had any surgery? If yes, please describe the problem, when it occurred, and where. _____

4. Have you ever had any sports-related injuries? If yes, please describe. _____

5. Do you have any restrictions on your physical activity? If yes, please describe. _____

6. Do you have allergies to food, medications, or latex? If yes, please describe. _____

7. Please list any medications, vitamins, supplements, or birth control that you take on a regular basis (include the name, dose, and frequency of the item). _____

8. Does your family have a history of any of the following (check appropriate box)?

- | | | |
|---|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Depression | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Intestinal disorders |
| <input type="checkbox"/> Chronic lung disease | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Kidney disease |

9. Explain any positive responses to the question above. _____

10. **Voluntary Self-Identification:** Please complete this question if you have a physical or learning disability and would like to receive information about specific services that may be available to facilitate your success in college. This question is optional, will remain confidential, and will in no way affect your academic or personal status at this college. Describe the nature of your disability.

PHYSICAL EXAMINATION

(to be completed and signed by your physician, PA, or NP)

Student Name: _____ **Date of Birth (Month/Day/Year):** ____/____/____

1. Please perform a physical examination of the student. Note that this examination will also be used to clear students to participate in intercollegiate athletics.
2. Sex: M F 3. Age: _____ 4. Weight: _____ 5. Height: _____ 6. BMI _____
7. Blood Pressure: ____/____ 8. Pulse: _____
9. Vision: Right 20/____ Corrected to 20/____ Left 20/____ Corrected to 20/____
10. Hearing: Right ____/25 Left ____/25
11. Urinalysis: Albumin: _____ Sugar: _____ HCT: _____ 12. Smoker: Yes No
13. In the space below, record and describe any abnormalities that you found during the examination.

System	Circle One	Description
Head, eyes, ears, nose, and throat	Normal or Abnormal	
Lungs, chest, and breasts	Normal or Abnormal	
Cardiovascular system	Normal or Abnormal	
Abdomen and viscera (include hernia)	Normal or Abnormal	
Musculoskeletal	Normal or Abnormal	
Endocrine system	Normal or Abnormal	
Genital and urinary system	Normal or Abnormal	Date of last PAP smear: _____
Skin and lymphatics	Normal or Abnormal	
Neurologic	Normal or Abnormal	

14. Is the student eligible to participate in intercollegiate athletics? If no, please describe any health condition that prevents this student from participating in physical and athletic activities: Yes or No (circle one)

15. I have reviewed the student's clinical history as given by the student. Yes or No (circle one)

16. Is the student under care for a chronic condition or serious illness? If yes, please describe and send a clinical report so we may provide continuity of care. Yes or No (circle one)

17. Describe any follow-up for the medical staff of the Center for Student Health and Psychological Services:

18. Provider Signature and Address (provider who performed the physical):

Name of Provider: _____ License Number: _____

Provider Address: _____

Phone Number: (_____) _____ - _____ FAX #: _____

Date of Exam: ____/____/____

Provider Signature: _____

Plattsburgh

STATE UNIVERSITY OF NEW YORK

RETURN ADDRESS

Please mail or fax this form to:

Linda Dragon
Center for Student Health
& Psychological Services
SUNY Plattsburgh
101 Broad Street
Plattsburgh, NY 12901-2681 USA

Tel.: (518) 564-2187 or Toll-free (866) 858-4089
Fax: (518) 564-2188

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FOR PARENTS AND GUARDIANS OF STUDENTS UNDER EIGHTEEN (notarized signature required)

In order to quickly procure any necessary emergency care for students and to protect the physicians and institutions involved, it is requested that you sign and have notarized the consent for emergency treatment below. Be assured that we will make every effort to immediately notify parents when serious accidents or illnesses come to our attention. However, since students often attend this university from great distances, this may be slow or even impossible by phone. Your cooperation in this matter is greatly appreciated.

I, _____, pursuant to the authority vested in me as _____ of
(your full name) (parent or legal guardian)

_____, do hereby authorize the medical staff of the State University of New York, upon
(student's full name)
consulting with a practicing physician or surgeon, to exercise for me and on my behalf, all rights and duties with reference to consenting appropriate medical, psychiatric, and surgical treatment, anesthetics, medicines, and hospitalization, including care and treatment, by any hospital/staff surgeon, physician, or radiologist that they deem necessary for the emergency care of my _____.
(son or daughter)

Signed: _____ Date: ____/____/____

Notary:
Subscribed before me this _____ day of _____ year of _____.