Plattsburgh

STATE UNIVERSITY OF NEW YORK

HEALTH REPORT

FOR THE CENTER FOR STUDENT HEALTH AND PSYCHOLOGICAL SERVICES

CONFIDENTIAL REPORT

Plattsburgh
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Before registering for classes, Plattsburgh State 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 that start in the Fall Semester or by **December 15** for students that 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. Social Security Number:_____/____/_______
3. Home Address:______________________________
4. Date of Birth (Month/Day/Year):_____/_____/_____ 5. Sex: M F
6. 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:______________________________
4. Home Phone Number: (_____) _____-_________
5. Work Phone Number: (_____) _____-_________

Health Insurance (to be completed by the student)

Plattsburgh State 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

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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)?

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

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 occured, 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)?

- ☐ Alcoholism
- ☐ Cancer
- ☐ Chronic lung disease
- ☐ Depression
- ☐ Diabetes
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Intestinal disorders
- ☐ 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.

____

____

____

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Immunization Record

(to be completed by a health care provider)

The State of New York and Plattsburgh State require that all students are immunized against measles (rubeola), mumps, and rubella; polio and tetanus/diptheria 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 (recommended but not required) Three doses required for all students 18 and under. For those 19 and over, record the date of previous doses but no additional doses should be given.					
6. Tetanus/Diptheria (recommended but not required) At least three doses required and the most recent must be within 10 years of the student's enrollment date.					
7. PPD (recommended within six months of the physical) An x-ray is required if the PPD is positive.	Date PPD Adminis-tered	Date PPD Interpreted	Result *(circle one)* Positive Negative	X-ray Date	X- ray Result *(circle one)* Positive Negative
8. Varicella (recommended but not required) 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.					
9. Hepatitis B Vaccine (recommended but not required) Three doses.					
10. Pneumovax (not required) One dose.					
11. Meningococcal (recommended but not required) One dose.					

12. StudentName:____ 13. Soc. Sec. #:______/_____/_________
14. Provider Signature and Address:____
Name of Provider:____
Provider Address:____
Phone Number:(_______) _____-_________ **Provider Signature:**____

Physical Examination

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

Student Name:____ **Soc. Sec. #**_______/_______/________

1. Please perform a physical examination on 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. Blood Pressure:_____/______

7. Pulse:__________ 8. Vision: Right 20/_____ Corrected to 20/_____ Left 20/_____ Corrected to 20/

9. Hearing: Right_____/25 Left_____/25

10. Urinalysis: Albumin:__________ Sugar:__________ HCT:__________ 11. Smoker: Yes No

12. 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	

13. 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)

____
____
____

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

15. 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)

____
____
____

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

____
____
____

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

Name of Provider:____ License Number:____________________

Provider Address:____

Phone Number: (_______) _______-__________ FAX #:_______________________________

Date of Exam: _______/_______/_______

Provider Signature:____

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Return Address

This report must be signed by the provider who performed the physical. Please mail or fax this form to:

Linda Dragon
Center for Student Health
& Psychological Services
Plattsburgh State
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 ___________.