FREDONIA
STATE UNIVERSITY OF NEW YORK

Fredonia Student Health Center
LoGrasso Hall, 280 Central Avenue
Fredonia, NY 14063
Phone: 716-673-3131
Fax: 716-673-4722

HEALTH HISTORY FORM

Before registration for classes, the MANDATORY IMMUNIZATION INFORMATION must be returned to the Student Health Center.

Last Name (Please Print) First | Middle | Gender

Fredonia ID #: | Date of Birth | Student Cell Phone Number

Permanent Address (Number and Street) | City or Town | State | Zip Code

Emergency Contact Name, Relationship | Home Telephone Number | Work Telephone Number

Part 1: HEALTH HISTORY

Drug Allergies: ______________________________

Current Medications: ______________________________

Medical/Psychological Conditions: ______________________________

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Please note that Counseling and Psychiatric services are available to all registered Fredonia students.
For more information visit the Student Counseling website at www.fredonia.edu/counseling or call 716-673-3424.

Part 2: PERMISSION FOR TREATMENT OF STUDENTS UNDER 18 YEARS OF AGE

For parents/guardians of Applicants under 18 years of age: In order to provide routine and/or emergent medical care, please sign the consent below. Be assured that we make every effort to notify parents at once in case of major injuries or serious illness.

I (your full name) ______________________________ pursuant to the authority vested in me as the parent/

guardian of (student's full name) ______________________________

Do herby authorize the clinical staff at the State University of New York at Fredonia's Student Health Center to provide routine medical care to my son/daughter. This care may include treatment for common illnesses, physical examinations for sports participation, ordering of laboratory tests, prescribing of medications and the administration of immunizations to meet New York State immunization requirements. Furthermore, I do hereby authorize the clinical staff of the State University of New York at Fredonia to seek emergency medical care from outside clinicians if they feel it is necessary.

Signed (parent/guardian) ______________________________ Date: ______________

Name: ______________________ **Fredonia ID#** __________

Part 3: HEALTH INSURANCE INFORMATION

Fredonia does not currently require students to have health insurance. However, it is strongly advised that health insurance be maintained on all students to cover outside medical care and emergencies.

Bring a copy of your insurance card to school. **Please also submit a copy of both sides of your insurance card to be kept on file in the Health Center**. Be aware of any restrictions to your coverage such as copays, deductables, or out of area coverage.

Part 4: IMMUNIZATION RECORDS (Required)

Please attach a copy of your immunization record from a previous school, health care provider or government agency. This immunization record MUST contain the following information:

Measles, Mumps and Rubella

The **New York State Public Health Law #2165 requires** all students taking six or more credits, born on or after January 1, 1957, to provide proof of immunity against measles, mumps, and rubella as follows:

Two doses of (MMR) Measles, Mumps and Rubella

- ☑ First dose given after first birthday
- ☑ Second dose after 15 months of age and at least 28 days from first dose. Combined MMR (measles, mumps and rubella) vaccine is recommended for both doses.

OR list individual vaccines

- ☑ 2 Measles (1st dose after 1st birthday; 2nd dose at least 28 days later
- ☑ 1 Mumps (After 1st birthday)
- ☑ 1 Rubella (After 1st birthday)

OR Titre date and result – NOTE: IF your titre test does not indicate immunity, you will need to receive the vaccine, per NYS law.

Part 5: MENINIGITIS INFORMATION RESPONSE FORM *(Required)*

New York State Public Health Law 2167 requires our students to learn about Meningitis and be aware of the availability of the meningitis vaccine (available at a cost from your health care provider or county health department). While you are not required to receive this vaccine, we strongly urge you to read the full information regarding meningitis provided and to consider immunization.

New York State Public Health Law requires you to select one of the statements below and provide your signature:

_____ I have received the immunization for meningitis within the past 10 years. Date received: __________

_____ I acknowledge the risks associated with meningitis and decline immunization.

Signed (Student): ______________________ Date: __________

Name: ______________________ **Fredonia ID#** ____________

Part 7: Mandatory Tuberculosis Screening Form (Required)

SECTION A: History of Tuberculosis (TB) ?

1. Have you ever been sick with tuberculosis? ______ Yes ______ No
2. Have you ever had a positive PPD, QuantiFERON-TB Gold test or T-SPOT? ______ Yes ______ No

SECTION B: At Risk for Tuberculosis (TB) ?

1. Were you born in , or have you lived, worked or visited for more than **one month** in any of the following: Asia, Africa, South America, Central America or Eastern Europe? ______ Yes ______ No

   If yes, what country? ______________________

   How long? ______________________

2. Do any of the following conditions or situations apply to you?

   a) Do you have a persistent cough? (3 weeks or more), fever, night sweats, fatigue, loss of appetite, or weight loss? ______ Yes ______ No

   b) Have you ever lived with or been in close contact to a person known or suspected of being sick with TB? ______ Yes ______ No

   c) Have you ever lived, worked or volunteered in any homeless shelter, prison/jail, hospital or drug rehabilitation unit, nursing home or residential healthcare facility? ______ Yes ______ No

Student Signature: ______________________ Date: ____________

If you answered "no" to all of the above questions, skip Section C.

If you answered "yes" to any of the above questions, your health care provider must complete Section C below.

SECTION C:

ATTENTION HEALTH CARE PROVIDER: If the patient answered "Yes" to any of the above questions, proof of a PPD, QuantiFERON-TB Gold or T-SPOT is REQUIRED . If PPD results are 10 mm or more, or QuantiFERON-TB Gold or T-SPOT are positive, a chest x-ray is REQUIRED. **Testing and/or chest x-ray must be done within one calendar year prior to admittance.** History of BCG vaccination does not prevent testing of a member in a high risk group.

PPD: Date Placed ____________ Date read: ____________ mm induration ____________

OR QuantiFERON-TB Gold or T-SPOT: Result Date: ____________ Result (attach report) ____________

Chest X-ray: ____________ Date of Chest x-ray ____________ Result ____________

If negative CXR and positive PPD, did student complete a course of INH? ______ Yes ______ No

If yes, when ____________ (month and year) and for how many months did student take INH? ____________

PROVIDER INFORMATION (REQUIRED)

____________ ____________ ____________

Signature/stamp of health care provider | Phone Number of practice | Date

Name: ______________________ **Fredonia ID#** ______________

Part 8: PHYSICAL EXAMINATION

(Required by the NCAA for all new Athletes – Recommended for all other students)

TO THE LICENSED HEALTH PROFESSIONAL (D.O., M.D, P.A. , N.P) PERFORMING THIS EVALUATION:
Please complete the physical examination and comment on all positive findings.

Allergies to Medications:

Height: ________ Weight: ________ BMI: ________ BP: ________ Pulse: ______ Vision: Right 20/ _____ Left 20/______

Hearing: Right ________ Left ________ Glasses? ______ Contacts? ______ Dental Appliance? (type) ____________

Date of Sickle Cell Solubility Test: ____________ Result: ____________ ******Required by the NCAA for ALL student athletes***

HISTORY: To your knowledge, does the student have any history of the following:

	Yes	No	Explanation
Arrhythmia/Murmurs			
Chest Pain			
Dyspnea on Exertion			
Shortness of Breath			
Family History of Heart Disease			
Syncope/Fainting			

PHYSICAL EXAM:

	Normal	Abnormal	Explanation
HEENT			
Neck/Thyroid			
Lungs/Chest			
Cardiovascular			
Abdomen			
Musculoskeletal/Spine			
Extremities			
Skin			
Neurologic/Psychiatric			

Physical Examination: Are there any conditions of which we should be aware (such as single organs, hematologic disorder, seizure disorder, recent surgery, recurrent infection) ? Describe fully. Use additional sheet if necessary.

PROVIDER INFORMATION:

Date of Exam ____________ (***Per NCAA, this exam must be completed no sooner than 6 months prior to the start of the sport.)***

I have reviewed the information above and make the following recommendations for his/her participation in athletics.

______ Cleared ______ Not Cleared ______ Cleared – f/u needed (explain below)

F/U Recommendations: ______________________________

I have conducted a physical examination of this patient. All medical/psychiatric conditions and therapies are noted above or on attached pages.

Healthcare Provider Name (print): ______________________________

Address: ______________________________

Phone: ______________________________

Healthcare Provider Signature: ______________________ Date: ____________