

# St. John Fisher College

## Mandatory Health History Form, Physical and Immunizations for Undergraduate Students

(6 credit hours or more)

### Exam Form Due:

Fall Semester: September 1st

Spring Semester: January 1st

### Immunizations Due:

Freshman: Great Beginnings

Transfer: Course Registration

### CHECK ALL THAT APPLY

- Freshman
- Transfer
- Athlete  
Sport \_\_\_\_\_
- Nursing Student
- Residential Student
- Commuter

Please check one:

- Fall Semester Year \_\_\_\_\_
- Spring Semester Year \_\_\_\_\_
- Summer Semester Year \_\_\_\_\_

This form provides a means of identifying students with special needs and is an historical basis for the provision of health care through the Wellness Center. Information on this form is **CONFIDENTIAL**; it is for the Wellness Center's use only; it will not be released without the student's consent, and it will not affect admission status.

Fisher ID #: _____	Birth Date (MM-DD-YY): ____ - ____ - _____
Last Name: _____ First Name: _____ MI: _____	
Address (Street): _____	
City: _____ State: _____ Zip Code: _____ Phone: (____) _____	
E-mail Address: _____ Cell Phone: (____) _____	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female      Citizenship: <input type="checkbox"/> U.S. <input type="checkbox"/> Other: _____	
<b><u>PERSON TO NOTIFY IN CASE OF AN EMERGENCY</u></b>	
Name: _____ Relationship: _____ <small style="display: inline-block; width: 150px; text-align: center;">Last Name</small> <small style="display: inline-block; width: 150px; text-align: center;">First Name</small>	
Address: _____	
City: _____ State: _____ Country: _____ Zip Code: _____	
Home Telephone Number: _____ Business Telephone Number: _____	
Cell Phone Number: _____ Email Address: _____	
<b><u>HEALTH INSURANCE INFORMATION</u></b>	
Name of Insurance Co.: _____ Policy #: _____	
Subscriber's Name: _____	
<b><u>AUTHORIZATION TO PROVIDE MEDICAL CARE</u></b>	
<b>I hereby authorize the St. John Fisher College Wellness Center to give medical and minor surgical care to (student name) _____ on his/her request and to arrange for such care as necessary in the event of emergencies.</b>	
_____ <b>Student Signature (if 18 years or older)</b>	_____ <b>Parent/Guardian Signature (if student under 18 years)</b>

# Mandatory Physical Examination for Full-Time Undergraduates

*Due by September 1st (Fall Semester) or January 1st (Spring Semester)*

*(To be completed during the year prior to entry to college.)*

*Transfer Students: Copy of original college entrance physical is acceptable*

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Date of Physical:** \_\_\_\_\_

**THIS SECTION TO BE COMPLETED BY HEALTH CARE PROVIDER:**

**Exam:** Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_\_ P: \_\_\_\_\_ T: \_\_\_\_\_ BMI: \_\_\_\_\_ Vision: L \_\_\_\_\_ R \_\_\_\_\_

**Statement as to student's physical and mental status, and any restrictions:**

<input checked="" type="checkbox"/> Check = Normal <input type="checkbox"/> Circle = N/A <input type="checkbox"/> Blank = Not Examined	Note Variances, Abnormal or Significant Findings
<input type="checkbox"/> <b>General:</b> Healthy appearing, in no acute distress	
<input type="checkbox"/> <b>Skin:</b> Warm, pink, dry with no rash or lesions	
<input type="checkbox"/> <b>Head/Face:</b> Normcephalic. Normal Hair Growth	
<input type="checkbox"/> <b>Eye:</b> Sclera white. PERRLA.	
<input type="checkbox"/> <b>Nose/Sinuses:</b> Sinuses nontender to palpation, nares	
<input type="checkbox"/> <b>Ears:</b> 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.	
<input type="checkbox"/> <b>Pharynx:</b> Good dental hygiene. No tonsillar hypertrophy. No erythema, swelling, injection, exudate or lesions of palate/pharynx. Uvula midline.	
<input type="checkbox"/> <b>Neck:</b> Supple with full ROM. No cervical adenopathy. No thyromegaly.	
<input type="checkbox"/> <b>Respiratory:</b> Respirations easy and nonlabored. Aerate all lobes well. Lungs clear to auscultation and percussion. No pleural rub heard.	
<input type="checkbox"/> <b>Cardiovascular:</b> Regular S1, S2 without murmur, gallop or rub. No peripheral edema.	
<input type="checkbox"/> <b>Abdomen:</b> Soft, nondistended with active bowel sounds x 4. No hepatosplenomegaly. No abdominal guarding, rigidity, tenderness or masses on palpation. No CVA tenderness.	
<input type="checkbox"/> <b>Musculoskeletal:</b> Extremities with full ROM, no varicosities.	
<input type="checkbox"/> <b>Neurologic:</b> Oriented x 3. Cranial nerves II-XII intact.	
<input type="checkbox"/> <b>Breast:</b> Symmetrical, no masses/lumps, no dimpling, no palpable nodes, no nipple discharge, no retraction, no tenderness, BSE discussed.	
<input type="checkbox"/> <b>Genitourinary:</b> External genitalia and hair distribution WNL, inguinal nodes WNL, no urethral lesions or tenderness.	
<input type="checkbox"/> <b>Psychiatric:</b> 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: \_\_\_\_\_

\_\_\_\_\_ Unrestricted athletic participation                      \_\_\_\_\_ No participation

\_\_\_\_\_ Conditional athletic participation                      \_\_\_\_\_ List further medical evaluation needed before participation allowed.

**Provider's Signature** \_\_\_\_\_ **MD, NP, PA**    **Date** \_\_\_\_\_

**Address** \_\_\_\_\_ **Telephone** (    ) \_\_\_\_\_

**City/State/Zip** \_\_\_\_\_ **Fax** (    ) \_\_\_\_\_

Please mail this completed form to: St. John Fisher College Wellness Center, 3690 East Avenue, Rochester, NY 14618  
Phone: (585) 385-8280 or Fax: (585) 385-8299

**IMMUNIZATIONS – Due at Great Beginnings (Freshman Students)  
or at Course Registration (Transfer Students)**

Submit this form **OR** immunization records from your school/personal physician. Fax to (585) 385-8299; mail to: Wellness Center, St. John Fisher College, 3690 East Ave, Rochester, NY 14618.  
*See Immunization Requirements page in this packet, explaining Proof of Immunity.*

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Fisher ID#: \_\_\_\_\_

Required Immunizations:	Disease	Vaccine Date (Please list dates: MM/DD/YY)	Titre Results and Date
	Measles * (Rubeola) 2 doses	/	
	Rubella* (German Measles) 1 dose		
	Mumps* 1 dose		
	Or combined as MMR 2 doses	/	

**Required Response Form** *(One dose, recommended at entry into college for freshmen living in dorms.)*

**CHECK ONE BOX ONLY:**

I have had the meningococcal meningitis immunization within the past 10 years.  
**Date received:** \_\_\_\_\_ Menactra    **Date Received:** \_\_\_\_\_ Menomune

I 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 (my child) will not obtain immunization against meningococcal meningitis disease.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
**Student Signature (or Parent/Guardian Signature if student under 18 years)**

*Please list vaccine dates for the following:*

Tdap/Td (Tetanus) \_\_\_\_\_ Meningitis \_\_\_\_\_

Hepatitis A: \_\_\_\_\_

Hepatitis B (3 doses): *Nursing students must receive the vaccine, have a positive titer, or sign a waiver.*  
Dose 1 \_\_\_\_\_ Dose 2 \_\_\_\_\_ Dose 3 \_\_\_\_\_

Tuberculin Skin test (PPD): Date given \_\_\_\_\_ Date read \_\_\_\_\_ Results \_\_\_\_\_

Varicella (Chicken Pox): \_\_\_\_\_

Gardasil: Dose 1 \_\_\_\_\_ Dose 2 \_\_\_\_\_ Dose 3 \_\_\_\_\_

\*\*\*\*\*

*I certify that the above is complete and accurate.*

Physician Name: \_\_\_\_\_ MD, NP, PA  
*Print or Stamp* *Signature*

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Date form completed: \_\_\_\_\_

**Please mail this completed form to: St. John Fisher College, Wellness Center, 3690 East Ave., Rochester, NY 14618**

**Student Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Fisher ID Number:** \_\_\_\_\_

*All students are required to complete and return this form  
to the Wellness Center at St. John Fisher College.*

Yes  No Do you have any drug allergies? Specify: \_\_\_\_\_

Yes  No Do you have any allergies to insect stings, foods, latex, or others? Specify: \_\_\_\_\_

Yes  No Do you have any family history of medically unexplained or cardiac-caused sudden death under the age of 50? Please explain. \_\_\_\_\_

Yes  No Do you have asthma? Please list medications you are taking for this condition. \_\_\_\_\_  
\_\_\_\_\_

Yes  No Do you have diabetes? Please list medications you are taking for this condition. \_\_\_\_\_  
\_\_\_\_\_

Yes  No Do you have hypoglycemia (low blood sugar)?

Yes  No Do you have any loss of paired-organ function (eye, kidney, testicle)?

Yes  No Have you had a previous concussion or loss of consciousness? Please explain. \_\_\_\_\_  
\_\_\_\_\_

Yes  No Have you ever fainted (syncope) or had near syncope with exercise?

Yes  No Have you ever had symptoms of exercised-induced bronchospasm?

Yes  No Have you ever had an incident of heart-related illness?

Yes  No Have you had any operations? If so, please list. \_\_\_\_\_  
\_\_\_\_\_

Yes  No Have you had any serious illnesses in the past? If so, please explain. \_\_\_\_\_  
\_\_\_\_\_

Yes  No Have you been hospitalized in the past five years? If so, please explain. \_\_\_\_\_  
\_\_\_\_\_

Yes  No Are you currently being treated for any chronic condition? If so, please explain. \_\_\_\_\_  
\_\_\_\_\_

Yes  No Do you have anxiety or depression? If so, please explain. \_\_\_\_\_  
\_\_\_\_\_

Please list all medications that you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_

**Student Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Note to Athletes: Your signature above authorizes the release of this information between the Wellness Center and the athletic training staff at St. John Fisher College.

Please mail or fax these forms to:

St. John Fisher College Wellness Center  
3690 East Avenue, Rochester, NY 14618  
Phone: (585) 385-8280 Fax: (585) 385-8299

# IMMUNIZATION REQUIREMENTS

## NEW YORK STATE PUBLIC HEALTH LAW 216 MANDATES THAT ALL INCOMING STUDENTS PROVIDE PROOF OF IMMUNITY AGAINST MEASLES, MUMPS, AND RUBELLA.

The laws of the State of New York require certain immunizations for college and other post-secondary students. As of August 1991, all full and part-time students taking 6 or more credit hours must submit immunization records for measles, mumps, and rubella. Students born prior to January 1, 1957 are exempt from these requirements, except nursing students born before 1/1/57, who must show proof of immunity to Rubella to participate in clinical experience. All nursing students entering a clinical course are required to have an annual physical examination (a copy of the annual health screen performed by health care employers is acceptable), Hepatitis B series, Hepatitis B surface antibody titer, or a signed waiver, and an annual PPD.

For the purpose of the college immunization law, the following are **REQUIRED**: proof of immunity for measles, mumps, and rubella, *and submission of the Meningitis Response Form*. READ THE FOLLOWING STATEMENTS FOR EXPLANATION OF REQUIREMENTS:

**MEASLES (Rubeola)**: Official record of two doses of live measles virus vaccine; given on or after 1-1-68; the first must be given on or after the first birthday and the second after 15 months of age, physician-documented history of disease, or serological evidence of immunity (titer).

**RUBELLA (German Measles)**: Official record of one dose of rubella vaccine given on or after 1-1-68 and to be given on or after the first birthday, or serological evidence of immunity (titer).

**MUMPS**: Official record of one dose of mumps vaccine given on or after 1-1-68 and to be given on or after the first birthday, physician-documented history of the disease, or serological evidence of immunity (titer).

**MENINGITIS RESPONSE FORM**: (see immunization page for requirement) **THE MENINGITIS VACCINATION IS NOT REQUIRED.**

In addition to the measles, mumps, and rubella immunizations, the American College Health Association (ACHA) strongly recommends that students entering college be vaccinated against tetanus, diphtheria, polio, varicella (chicken pox), Hepatitis B, and meningitis, although at this time they are not mandated by law.

Please consult with your **health care provider, former high school nurse, former college, or public health clinic** to obtain an official copy of your immunizations. Review your immunization record with your health care provider so that he/she can administer any additional doses of vaccine that you may need. **To avoid a last minute rush to comply with these regulations, it would be advisable to make an appointment well in advance of the beginning of the school year.**

Students who are not compliant will be pulled from their classes one month after classes start and a **\$300.00** reinstatement fee added to their bill when proper documentation has been received at the Wellness Center. If the State reviews our files and finds that a student is not compliant, the College is fined. This fine of approximately \$2,000.00 is added to the student's bill. Your immunization records may be **faxed to (585) 385-8299** or mailed to the Wellness Center prior to submitting the Health History Form.

All clinical nursing students need to have proof of immunity to Rubella, 3 doses of Hepatitis B, a positive titer or signed waiver; annual PPD, annual physical, and tetanus booster within the last 10 years. Clinical nursing students born on or after January 1, 1957, will also need two measles (Rubeola) and one mumps immunization.

**Please submit your immunizations to the Wellness Center, St. John Fisher College, Dorsey Hall, 3690 East Avenue, Rochester, NY 14618, (585) 385-8280.**

# **Meningococcal Disease Information**

*Information for College Students and Parents of Children at Residential Schools*

## **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).

## **Who gets meningococcal disease?**

Anyone can get meningococcal disease, but it is more common in infants and children. For some college students, such as freshmen living in dormitories, there is an increased risk of meningococcal disease. Between 100 and 125 cases of meningococcal disease occur on college campuses every year in the United States; between 5 and 15 college students die each year as result of infection. Currently, no data are available regarding whether children at overnight camps or residential schools are at the same increased risk for disease. However, these children can be in settings similar to college freshmen living in dormitories. Other persons at increased risk include household contacts of a person known to have had this disease, and people traveling to parts of the world where meningitis is prevalent.

## **How is the germ meningococcus spread?**

The meningococcus germ is spread by direct close contact with nose or throat discharges of an infected person. Many people carry this particular germ in their nose and throat without any signs of illness, while others may develop serious symptoms.

## **What are the symptoms?**

High fever, headache, vomiting, stiff neck and a rash are symptoms of meningococcal disease. Among people who develop meningococcal disease, 10-15% 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.

## **How soon do the symptoms appear?**

The symptoms may appear two to 10 days after exposure, but usually within five days.

## **What is the treatment for meningococcal disease?**

Antibiotics, such as penicillin G or ceftriaxone, can be used to treat people with meningococcal disease.

## **Is there a vaccine to prevent meningococcal meningitis?**

Yes, a safe and effective vaccine is available. The vaccine is 85% to 100% effective in preventing four kinds of bacteria (serogroups A, C, Y, W-135) that cause about 70% of the disease in the United States. The vaccine is safe, with mild and infrequent side effects, such as redness and pain at the injection site lasting up to 2 days. After vaccination, immunity develops within 7 to 10 days and remains effective for approximately 3 to 5 years. As with any vaccine, vaccination against meningitis may not protect 100% of all susceptible individuals.

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

Contact your family physician or your student health service. Additional information is also available on the websites of the New York State Department of Health, [www.health.state.ny.us](http://www.health.state.ny.us); the Centers for Disease Control and Prevention [www.cdc.gov/ncid/dbmd/diseaseinfo](http://www.cdc.gov/ncid/dbmd/diseaseinfo); and the American College Health Association, [www.acha.org](http://www.acha.org).