



Office of Student Health Services

Physical Examination and Immunization Form

No information regarding your past or present status will be released to anyone without your written consent. Physical examinations must have been given **within the past 12 months** of the start date of the semester. **Graduate** students do **not** need an examination; however, TB Screening is mandatory by Health Provider. Return this completed form **one month prior to the first day of the semester** to:
Student Health Services, P.O. Box 1923, Niagara University, NY 14109-1923 or fax to: **716-286-8391**.

Your Information

Last Name		First Name		Middle Initial	Citizenship
Month	Day	Year	Social Security Number	Student ID	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth				Gender	
Street Address		City	State	Zip Code	
Home Phone		Cell Phone	Personal Email (Print Clearly)		

Emergency Contact

Emergency Contact – Name and Relationship		Email Address	Home Phone	
Street Address	City	State	Zip Code	Work Phone

Personal Physician

Primary Physician	Address	Phone	Fax
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Parent / Guardian Authorization for Student Under 18 Years of Age

I authorize the Student Health Center of Niagara University to provide care and treatment to my child/legal ward. I give permission for treatment that may include, but not limited to, routine, urgent and emergency care, medicines, immunizations, laboratory diagnostic studies, referral to hospitals, clinics or a medical specialist deemed necessary by the college's medical and nursing staff.

Signature of Parent / Guardian	Date
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Name _____ Date of Birth _____

Medical History / Student to complete and sign

Please check if you have ever had or are currently under treatment for any of the following. Explain all checked items.

- General**
- Chicken Pox
 - German measles (rubella)
 - Measles
 - Mumps
 - Mononucleosis
 - Meningitis
 - Scarlet Fever
 - Anemia
 - Thyroid Disorder
 - Diabetes Mellitus
 - Cancer
 - Immune Deficiency
 - Serious Accident/Injury
- Skin Disorder**
- Eczema
 - Hives
 - Acne
 - Chronic Rash
 - Tattoos/Piercings
 - Skin Disorder
- Respiratory**
- Asthma
 - Shortness of Breath/Exercise
 - Pneumonia
 - Tuberculosis
 - Recurrent Bronchitis
 - Recurrent Sinusitis
 - Recurrent Nosebleeds
 - Recurrent Ear Infection
 - Recurrent Cold
 - Frequent Sore Throat

- Cardiac**
- Marfan's Syndrome
 - Congenital Condition
 - Mummur
 - Rheumatic Heart Disease
 - High Blood Pressure
 - Heart Palpitations
 - Chest Pain/Pressure
 - High Cholesterol
 - Other _____
- Uro-Genital**
- Recurrent Bladder Infection
 - Blood in Urine
 - Kidney Infection
 - Kidney Stones
 - Frequent Urination
 - Chronic Kidney Disease
 - STD
- Female**
- Age of first period _____
 - Pelvic/Vagina; Infection
 - Painful Periods
 - Heavy Flow
 - Irregular Periods
 - Pregnancy
 - Ovarian Cysts
 - Polycystic Ovary Disease
- Male**
- Testicular Lump
 - Testicular Torsion

- Mental/Emotional**
- Anger Management
 - Eating Disorder
 - Drug/Alcohol Dependency
 - Depression
 - Learning
 - ADD/ADHD
 - Panic/Anxiety Disorder
 - Bipolar Disorder
 - Mood Disorder
 - Obsessive Compulsive Disorder
 - Schizophrenia
 - Deliberate Self Harm
 - Hospitalization for Emotions
 - Trouble Sleeping
 - Other _____
- Musculoskeletal**
- Bone Fractures
 - Joint Injury
 - Arthritis
 - Scoliosis
 - Back Pain/Problems
 - Osgood Schlatter
 - Tendinitis
 - Other Musculoskeletal
- Neurological**
- Neurological Disorder
 - Head Injury/Loss Consciousness
 - Paralysis
 - Fainting/Dizziness/Syncope
 - Seizure Disorder

- Migraine Headaches
 - Tension Headaches
 - Vision/Glasses/Contacts
 - Hearing difficulty/loss
 - Speech difficulties
- Gastro Intestinal**
- Ulcer
 - Inflammatory Bowel Syndrome
 - Irritable Bowel Syndrome
 - Hepatitis
 - Pancreatitis
 - Gall Bladder
 - Reflux
 - Hernia
 - Rectal Bleeding
- Loss of Organ**
- Kidney
 - Ovary
 - Eye
 - Testicle
 - Other _____

Habits

Do you use tobacco?
 No _____ Yes _____
 Packs per day _____

Do you drink alcohol?
 No _____ Yes _____
 Amount per week _____

Current medicines (including vitamins and supplements): _____

Explanation for the above: _____

Family History	Age	State of Health	Occupation	Age of Death	Cause of Death
Father					
Mother					
Brothers					
Sisters					

Allergies please check below
 seasonal allergies _____
 Allergies to medications/x-ray dyes _____
 Anaphylactic Reaction _____
 Please list all _____

Have any of your relatives had any of the following?

	Yes	Relationship		Yes	Relationship
Alcoholism			Stomach Disease		
Tuberculosis			Mental Illness		
Arthritis			Sudden Death from non-toxic causes		
Asthma, Hay Fever			Marfan's Syndrome		
Diabetes			Kidney Disease		
Epilepsy, Convulsions			Other (specify)		
Heart Disease					

Surgeries _____

- Appendectomy/Tonsils/Adenoids
- Hernia repair
- Mole removal
- Other _____

I verify that all medical and psychological information I have provided is complete and accurate.
 I will notify the Student Center hereafter of any changes in my health that occur while a student at Niagara University.
 Signature _____ Date _____

Name _____ Date of Birth _____

Immunizations / Student may submit with certified immunization record or healthcare provider can complete and sign.

REQUIRED IMMUNIZATIONS – New York State PHL Section 2165

MMR (Measles, Mumps, Rubella) Date of: Dose #1 _____ Dose #2 _____

IF born on or after 1/1/57 two doses of live vaccine required. First vaccine must be given on or after first birthday. Second vaccine must be given after 15 months of age and at least 28 days after the first vaccine.

Measles (2 vaccines) Dose #1 _____ Dose #2 _____ Disease Date _____ Serology Date _____ Immune

Mumps (1 vaccine) Dose #1 _____ Disease Date _____ Serology Date _____ Immune

Rubella (1 vaccine) Dose #1 _____ Serology Date _____ Immune

Meningitis Response – New York State PHL Section 2167.

ALL STUDENTS MUST COMPLETE THIS RESPONSE (INCLUDING THOSE BORN BEFORE 1/1/57)

Date of Meningococcal Immunization within past 10 years:

One dose of either Menomune™ or Menactra™ Month _____ Day _____ Year _____

I have read or had explained to me the fact sheet enclosed regarding meningococcal disease and am declining the vaccine at this time. I am fully aware of the risks associated with the disease and of the availability and effectiveness of the vaccine.

Signature of student (or parent/guardian if student is under 18) Date

N C T	Varicella Vaccine	Susceptible students 13 years of age, two doses 4-8 weeks apart of date of 1 dose before 13 years of age, disease date or serology results	Date of:	Dose #1 _____	Dose #2 _____	
			Disease Date _____	Serology Date _____	<input type="checkbox"/> Immune	
R	Tetanus, Diphtheria, Pertussis	Dose within 10 years. Please specify <input type="checkbox"/> Td <input type="checkbox"/> Tdap	Month _____	Day _____	Year _____	
E	Polio Vaccine	Date series was completed:	Month _____	Day _____	Year _____	
U	Hepatitis B Vaccine	Series of 3 doses:	Dose #1 _____	Dose #2 _____	Dose #3 _____	
R	Hepatitis A Vaccine	Series of 2 doses:	Dose #1 _____	Dose #2 _____		
E						
D	HPV (Female Only)	Series of 3 doses:	Dose #1 _____	Dose #2 _____	Dose #3 _____	

Health Insurance: Are you covered in a **Health Insurance Plan** for the semester you are applying for?

YES (Please provide a copy of your health insurance card)

NO

All international students are mandated to have Health Insurance with appropriate coverage, if you do not have health insurance, it will be purchased for you on the first day of classes. See our webpage at: www.niagara.edu/healthcenter, International Health Insurance refer to Form1 and Form 2.

Signature Date

Signature Date

Student signature if accompanied with certified immunization record.

Physicians Signature if filled out by physician

Physical Examination – To be completed by Healthcare Provider

Name _____ Date of Birth _____ Gender: M F

Height _____ Weight _____ Blood Pressure _____ Pulse _____ Visual Acuity _____

Laboratory Tests: (Required for sports participation) Hemoglobin WNL Abnormal

Clinical Evaluation	Normal	Abnormal	Comments
1. Skin			
2. Head, Ears, Eyes, Nose, Throat, Hearing			
3. Mouth, Teeth, Gums			
4. Neck and Thyroid			
5. Chest/Lungs			
6. Breast			
7. Heart (supine and standing)			
8. Abdomen			
9. Genitalia			
10. Back/Spine			
11. Extremities/Musculoskeletal/Femoral Pulse			
12. Neurologic			
13. Emotional/Psychological			

Recommendation for physical activity: Unlimited Limited (explain) _____

The student is able to meet the physical and emotional demands of college life:

Yes No (explain) _____

TB Screening:

- Does the student have signs or symptoms of active TB disease? No Yes, proceed to question #2.
- Is the student a member of a high risk group or an international student from a country where TB is endemic arriving within the last 5 years? Yes No- **STOP** if answers are No, no further evaluation is needed at this time. If any are **YES** please administer PPD test.
- Tuberculin Skin test: (Mantoux) Date given: _____ Date read: _____
- Results: _____ mm Normal Positive
Chest x-ray required for positive PPD Date: _____
- Treatment Plan if indicated: _____

I have examined this student and attest the above information is accurate and complete to the best of my knowledge.

Signature of Healthcare Provider: _____ Date: _____

| _____ | _____ | _____ | _____
Print Name of Healthcare Provider Address Phone Fax