D'Youville

HEALTH CENTER
HEALTH AND IMMUNIZATION REPORT
Marguerite Hall • 1st Floor
505 Prospect Avenue
Buffalo, N.Y. 14201
Phone: 716.829.8777 Fax: 716.829.7646
E-mail: healthcenter@dyc.edu

PLEASE PRINT

Date of Birth: ____/_____/_____ Semester _____ & Year of Entry: _____ Program:_____

Name:_____ ❑ Male ❑ Female
Last Name First Name M.I.

_____ (_____) _____
Complete Permanent Address Street City State/Province Zip/Postal Code Telephone Number with Area Code

Country of Birth:_____ SS#/SIN: _____

_____ (_____) _____
Name and Relationship of Person to be notified in case of emergency Telephone Number with Area Code

Hospital Preference_____

_____
Health Insurance Coverage Company Name Policy Number (Numbers)

D'YOUVILLE COLLEGE STRONGLY RECOMMENDS ALL STUDENTS HAVE HEALTH INSURANCE.
THE HEALTH CENTER CAN DIRECT YOU ON INSURANCE POLICIES

AUTHORIZATION FOR HEALTH SERVICES

Permission is hereby granted to the D'Youville College **HEALTH CENTER** to administer medical services.

Permission is also granted in the event of an emergency to:

1. perform emergency procedures and administer medical care;
2. to refer the student to a duly licensed physician, surgeon, dentist or recognized hospital;
3. to grant on my behalf to any such licensed physician, surgeon, dentist or recognized hospital permission to perform any diagnostic, medical or surgical treatment deemed appropriate by the college health service or such physician, surgeon, dentist or recognized hospital.

The law requires that before medical or dental services can be performed for a person under 18 years of age, permission must be secured from the parent or guardian. Signing below grants this permission.

_____ _____/_____/_____
Signature of student, if over 18 years of age **Date**

_____ _____/_____/_____
Signature of parent/guardian, if under 18 years of age **Date**

Please make a copy for your records

REPORT OF MEDICAL HISTORY

Please complete this section before going to your physician.

Family History						Have Any Of Your Relatives Had Any Of The Following?				
	Age	State of Health	Occupation	Age at Death	Cause of Death		Yes	No	Self	Relationship
Father						Tuberculosis				
Mother						Diabetes				
Brother(s)						Kidney Disease				
						Heart Disease				
						Arthritis				
Sister(s)						Stomach Disease				
						Asthma, Hay lever				
						Epilepsy, Convulsions				
Children						Other Allergies				
						Cancer				
						Emotional Disorder				
						Any Other				

PERSONAL HISTORY

	YES	NO
Scarlet Fever	❑	❑
German Measles	❑	❑
Mumps	❑	❑
Chicken Pox	❑	❑
Whooping Cough	❑	❑
Typhoid Fever	❑	❑
Encephalitis	❑	❑
Malaria	❑	❑
Pneumonia	❑	❑
Convulsions	❑	❑
Diphtheria	❑	❑
Stomach Disorders	❑	❑
Diabetes	❑	❑
Tuberculosis	❑	❑
Rheumatic Fever	❑	❑
Kidney Disorder	❑	❑
Asthma, Allergies	❑	❑
Sinusitis	❑	❑
Polio	❑	❑
Colitis	❑	❑
High Blood Pressure	❑	❑
Sexually Transmitted Disease	❑	❑
Ear, Nose, Throat Infections	❑	❑
Multiple Sclerosis	❑	❑
Cancer, Cyst, Tumor	❑	❑
Heart Disorder	❑	❑
Gall Bladder Disease	❑	❑
Back Problem	❑	❑
Eating Disorder	❑	❑
Any Other ?	❑	❑

If yes, explain: _____

FEMALES

Irregular Periods	❑	❑
Severe Cramps	❑	❑
Excessive Flow	❑	❑

If yes, explain: _____

Do you wear glasses? ❑ YES ❑ NO
Do you wear contact lenses? ❑ YES ❑ NO
Is your hearing impaired? ❑ YES ❑ NO
Do you have frequent headaches? ❑ YES ❑ NO

Do you take allergy medication or injections? ❑ YES ❑ NO
If so, what: _____

Are you allergic to any drugs/medications? ❑ YES ❑ NO
If so, please list: _____

Are you allergic to any food(s)? ❑ YES ❑ NO
If so, please list:
_____

Have you had surgery? ❑ YES ❑ NO
If so, please list with date(s):
_____
_____
_____
_____

Have you had any serious injury? ❑ YES ❑ NO
If so, list with date(s):
_____
_____
_____

Do you have any limitations on activities? ❑ YES ❑ NO
If so, why and by whom?
_____
_____
_____

SIGNATURE: _____ Date: _____/_____/_____

PHYSICAL EXAMINATION
TO BE COMPLETED BY YOUR FAMILY PHYSICIAN

NAME _____ Date of Birth: ____/____/____

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Vision: With Glasses: [L] ____ [R] ____
Without Glasses: [L] ____ [R] ____

	Normal	Abnormal	Comments:
1. Ear, Nose	❑	❑	_____
& Throat	❑	❑	_____
2. Oral Cavity	❑	❑	_____
3. Neck	❑	❑	_____
4. Lungs, Chest	❑	❑	_____
5. Heart	❑	❑	_____
6. Abdomen	❑	❑	_____
7. External Genitalia	❑	❑	_____
8. Rectum	❑	❑	_____
9. Extremities	❑	❑	_____
10. Neurological	❑	❑	_____
11. Menstrual Cycle (females)	❑	❑	_____

Is student taking any medication? ❑ YES ❑ NO
If so, what medication?

_____

_____

Reason or conditions for medication:

_____

_____

_____

Has student been vaccinated with BCG? ❑ YES ❑ NO
If yes, what year? _____

Any allergies? ❑ YES ❑ NO
If any, please list:

_____

_____

_____

Is there any history of emotional disorders? ❑ YES ❑NO

_____

_____

Are there any physical problems? ❑ YES ❑ NO

_____

_____

PARTICIPATION IN CLUB/SPORTS

Recommendation for physical activities, including participation in club, intramural & intercollegiate sports:

❑ Unlimited ❑ Limited

If limited, please explain:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____
Signature Of Healthcare Provider

_____
Print or Stamp Name Of Healthcare Provider

Date: _____/_____/_____

Address: _____

_____

Phone: ( ) _____

Fax: ( ) _____

NOTICE! IT'S THE LAW! NO SHOTS - NO REGISTRATION

NYS PUBLIC HEALTH LAW 2165 requires college students to show proof of immunity to Measles. Mumps and Rubella. Persons born prior to 1/1/57 are exempt from this requirement unless required by their academic major to meet clinical placement requirements. If you are exempt, you must provide proof of age. NYS PUBLIC HEALTH LAW 2165 requires colleges to distribute information about meningococcal disease and vaccination to all students.

Name: _____ Date of Birth: __/___/___

MENINGITIS VACCINATION RESPONSE FORM

To be completed and signed by student or parent/guardian for student under the age of 18. One dose of meningitis vaccine within 10 years is recommended by NYS PHL §2167.

Check one box only and sign below.

I have/my child:

❑ had the meningococcal meningitis immunization (ie: Menactra ™) within the past 10 years. Date of vaccination: ____/____/____

❑ read the meningitis information found on the D'Youville College Web site under "Health Center" 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 (or my child) will NOT obtain immunization against meningococcal meningitis disease.

_____ ____/____/____

Student signature required. If student is a minor, parent or guardian signature required. **Date**

REQUIRED NEW YORK STATE IMMUNIZATIONS (MUST INCLUDE MONTH, DAY, YEAR)

Must be completed and signed by health care provider or attach immunization records from previous school, health care provider or government agency.

REQUIRED: MEASLES (RUBEOLA) IMMUNITY

Must have one of the following:

1. Two dates of measles immunization: (1) ___/___/___ (2)___/___/___ Both must have been given after 1/1/68 and on/after first birthday.

OR 2. Date of positive measles titer: ___/___/___ Results: _____ **Copy of titer required.**

REQUIRED: MUMPS IMMUNITY

Must have one of the following:

1. Date of one mumps Immunization: ___/___/___ Must have been given after 1/1/69 and on or after first birthday.

OR 2. Date of positive mumps titer: ___/___/___ Results: _____ **Copy of titer required.**

REQUIRED: RUBELLA IMMUNITY

Must have one of the following:

1. Date of one rubella immunization: ___/___/___ Must have been given after 1/1/69 and on or after first birthday.

OR 2. Date of positive rubella titer: ___/___/___ Results: _____ **Copy of titer required.**

MENINGITIS IMMUNITY(not required):

Meningococcal immunization {ie: Menactra ™) within the past 10 years. Date of vaccination: ____/____/____

RECOMMENDED VACCINES

Students in health-related profession programs are required to provide proof of PPD, Tetanus (within 10 years}, Hepatitis B series, and Varicella vaccine or proof of immunization. Vaccines listed below are not required for students in other academic programs, but they are recommended

1. Tetanus/Diphtheria: ❑ TD or ❑ Tdap Date: ____/____/____ (required every 10 years)

2. PPD (Mantoux} Date administered: ____/____/____ Date read: ____/____/____ Results: _____

If positive PPD, Chest X-Ray results: Date: ____/____/____ *(Copy of X-ray report required)*

3. Hepatitis B Vaccine 1st: ___/___/___ 2nd: ___/___/___ 3rd: ___/___/___

or **Hepatitis B Titer:** Date: ___/___/___ Results: _____ *(Copy of lab reports required.)*

4. Rubella Titer: Date: ___/___/___ Results: _____ *(Copy of lab report required)*

5. Chicken Pox Titer: Date: ___/___/___ Results: _____ *(Copy of lab report required.)*

_____

MD/DO/NP/PA Signature Date

_____

Print or Stamp Name here

_____

Address (Area Code) Telephone/Fax Number