



# ELMIRA COLLEGE HEALTH FORM

1. **Pages 1 and 2** are to be completed by the student. **Pages 3 and 4** are to be completed and signed by your health care provider (physician, nurse practitioner or physician's assistant). Upon completion, forward immediately to:

Clarke Health Center  
One Park Place  
Elmira College  
Elmira, New York 14901

2. If your completed Health Form is not on file at the Health Center one month prior to arrival to Campus, a fee of \$100 will be charged to your Elmira College account. An additional fee of \$100 will be added each month if you fail to meet this requirement. **Fill out this form completely and do not send immunization attachments.**
3. Information contained on this form is confidential and solely for the Health Center and will not be released without the student's consent and in no way affects the student's college standing. The purpose of this form is to help the Health Center Staff render the student effective aid and medical care.

NAME AND CLASS YEAR: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_ SOC. SEC. #: \_\_\_\_\_

\_\_\_\_\_  
City State Zip CELL PHONE #: \_\_\_\_\_  
TELEPHONE#: \_\_\_\_\_

FULL NAME OF PARENT OR GUARDIAN: \_\_\_\_\_

NAME OF PERSON TO NOTIFY IN CASE OF EMERGENCY: \_\_\_\_\_

RELATIONSHIP TO STUDENT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ TELEPHONE #: (H) \_\_\_\_\_

\_\_\_\_\_  
City State Zip (W) \_\_\_\_\_

(C) \_\_\_\_\_

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**PLEASE SEND COPY OF INSURANCE AND PRESCRIPTION CARDS (Front and Back)**

NAME OF CURRENT HEALTH INSURANCE COMPANY: \_\_\_\_\_

SUBSCRIBER'S NAME & PLACE OF EMPLOYMENT: \_\_\_\_\_ SOC. SEC. # \_\_\_\_\_

INSURANCE COMPANY ADDRESS: \_\_\_\_\_

\_\_\_\_\_  
City State Zip

CONTRACT #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

Many insurance companies require prior approval before obtaining services rendered outside the Clarke Health Center. (throat and urine cultures, bloodwork, x-rays or referral) **These prior approvals and arrangements will be the student's responsibility.** Please contact your insurance company to know what needs to be done prior to student's arrival to campus.

Health Insurance is required for all full-time students. You must enroll in a policy made available by the College or sign a waiver with proof of coverage under another plan.

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Please indicate any allergies you have:

- \_\_\_\_\_ I have no known allergies.
- \_\_\_\_\_ Aspirin
- \_\_\_\_\_ Codeine
- \_\_\_\_\_ Environmental (please specify):
- \_\_\_\_\_ Food (please specify):
- \_\_\_\_\_ Latex
- \_\_\_\_\_ Penicillin or Ampicillin
- \_\_\_\_\_ Sulfa
- \_\_\_\_\_ Other (please specify):

**FAMILY MEDICAL HISTORY:**

If any of your blood relatives had the diseases listed, check in the space provided (includes parents, grandparents, brothers, sisters, children).

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Alcoholism                       | <input type="checkbox"/> Dilated Cardiomyopathy      | <input type="checkbox"/> Marfan's Syndrome   |
| <input type="checkbox"/> Anemia                           | <input type="checkbox"/> Heart Disease               | <input type="checkbox"/> Mental Illness  |
| <input type="checkbox"/> Bleeding Tendency                | <input type="checkbox"/> Hereditary Disorder _____   | <input type="checkbox"/> Obesity   |
| <input type="checkbox"/> Breast Cancer prior to menopause | <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> Premature death or morbidity from cardiovascular disease at younger than 50 |
| <input type="checkbox"/> Cancer                           | <input type="checkbox"/> Hypertrophic Cardiomyopathy | <input type="checkbox"/> Stroke  |
| <input type="checkbox"/> Diabetes                         | <input type="checkbox"/> Long QT Syndrome            | <input type="checkbox"/> Tuberculosis  |

**STUDENT MEDICAL HISTORY:**

Indicate Past or Present:

- |  |  |
|--|--|
| <input type="checkbox"/> Allergic Rhinitis   | <input type="checkbox"/> Peptic Ulcer  |
| <input type="checkbox"/> Anxiety   | <input type="checkbox"/> Pregnancies-abortion  |
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> Psychiatric Illness _____   |
| <input type="checkbox"/> Blood Abnormality (Anemia, Bleeding Trait, Sickle Cell—please circle) | <input type="checkbox"/> Recurrent Ear Infections  |
| <input type="checkbox"/> Cancer or Malignancy  | <input type="checkbox"/> Rheumatic Fever   |
| <input type="checkbox"/> Chicken Pox Date: _____   | <input type="checkbox"/> Seizure Disorders (Epilepsy)  |
| <input type="checkbox"/> Counseling  | <input type="checkbox"/> Sexually Transmitted Disease  |
| <input type="checkbox"/> Depression  | <input type="checkbox"/> Sleeping Issues _____   |
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Substance or Alcohol Abuse  |
| <input type="checkbox"/> Eating Disorders  | <input type="checkbox"/> Surgeries (please list): _____  |
| <input type="checkbox"/> Excessive unexplained shortness of breath or fatigue with exercise    | _____  |
| <input type="checkbox"/> Fractures   | <input type="checkbox"/> Tuberculosis or past positive TB test   |
| <input type="checkbox"/> Hypertension (Elevated Blood Pressure)                                | <input type="checkbox"/> Urinary Tract Infections  |
| <input type="checkbox"/> Ileitis-Colitis   | <input type="checkbox"/> Viral Hepatitis   |
| <input type="checkbox"/> Infectious Mononucleosis (Mono)                                       | <input type="checkbox"/> Prior Chest Pain with exercise  |
| <input type="checkbox"/> Knee Injury   | <input type="checkbox"/> Prior dizziness or fainting with exercise   |
| <input type="checkbox"/> Menstrual Problems  | <input type="checkbox"/> Prior history of heart murmur or increased blood pressure other than resolved functional murmur. Please send copy of EKG and Echo Report. |
| <input type="checkbox"/> Migraine Headaches  | <input type="checkbox"/> Other: _____  |
| <input type="checkbox"/> Pelvic Infection  | <input type="checkbox"/> None Apply  |

Do you consider yourself **Challenged** in any way? If so, please give specifics.

- |                    |                  |
|--------------------|------------------|
| Vision: _____      | Emotional: _____ |
| Hearing: _____     | Learning: _____  |
| Mobility: _____    | Other: _____     |
| Other motor: _____ |                  |

**CONSENT FOR TREATMENT, DISCLOSURE OF HEALTH INFORMATION, VERIFICATION OF HEALTH HISTORY, AND PROVISION OF MENINGITIS INFORMATION**

- This is an agreement between you, the student (or representative if under age 18) and the Clarke Health Center.
- When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.
- By signing this consent you are agreeing to let us use your health information at the Clarke Health Center and with authorization send it to others. The enclosed Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this consent. After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on.
- I verify that all medical and psychological information I provided is complete and accurate. I will notify the Clarke Health Center here after of any changes in my health that occur while a student at Elmira College.
- I have read the provided information about meningitis infection and the availability of a vaccine to prevent meningitis A, C, Y, and W-135.

**If you do not sign this consent agreeing to what is in our Notice of Privacy Practices, we cannot treat you.**

\_\_\_\_\_  
Signature of student (if student is under 18, signature of parent or guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of student representative (if applicable)

\_\_\_\_\_  
Relationship to student

# PHYSICAL EXAMINATION

**Please fill out completely.**

We require that the Exam be done by a practitioner other than the student's relative. Please note, any abrupt changes in medication before college is not recommended without sufficient monitoring at home. Please refer any student in need of counseling services at college to (607) 735-1750.

**STUDENT'S NAME:** \_\_\_\_\_ **Class Year:** \_\_\_\_\_ **D.O.B.** \_\_\_\_\_

Sex:	Age:	Brachial Blood Pressure Sitting:	Pulse:	Height:	Weight:
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VISION:	Far: Right 20/	Corr. to 20/	Far: Left 20/	Corr. to 20/
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URINE:	Alb:	Sug:	Sp.Gr.	HEARING:	Right:	Left:
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CLINICAL EVALUATION FOR <b>ALL</b> STUDENTS (NCAA requires cardiac pre-screening and sickle cell trait screening for athletic participation) <b>Check each item in proper column</b>	NORMAL	ABNORMAL	Note: Give details of each abnormality with corresponding item #
1. Head, Neck, Face and Scalp			
2. Nose and Sinuses			
3. Mouth, Throat, Teeth and Gingiva			
4. Ears (perf. of drum, etc.)			
5. Eyes (lids, conjunctiva, etc.)			
6. Pupils and Ocular Motion			
7. Lungs, Chest, and Breasts			
8. Heart: (If history of murmur please send EKG and Echo report) a) Auscultation-supine/standing b) Femoral artery pulses c) Estimate of cardiac function			
9. Abdomen and Viscera (include hernia)			
10. Ano-rectal (pilonidal)			
11. Testicular-Pelvic exam			
12. Upper Extremities (strength, range of motion)			
13. Feet			
14. Lower Extremities (as for upper)			
15. Spine, other Musculo-skeletal			
16. Skin and Lymphatics			
17. Neurologic			
18. Psychiatric (specify any personality deviations)			
19. Recognition of Marfan's Syndrome			
20. Sickle Cell Trait status			

Any operations, serious injuries, or serious illness not noted above? \_\_\_\_\_

Please indicate any limitations to college level physical activity: sports, dance, ROTC, intramurals, community service, and travel: \_\_\_\_\_

Please list any prescription medication \_\_\_\_\_

Please attach or forward any medical records that may be needed in order to provide appropriate care to the student while at college.

Date: \_\_\_\_\_ Signature of Examining Physician: \_\_\_\_\_

Telephone: \_\_\_\_\_ Address: \_\_\_\_\_ Street City State Zip

**IMMUNIZATION RECORD**

**NO ATTACHMENTS ACCEPTED. Fill out completely. Practitioner, please sign below.**

<p><b>DIPHTHERIA-PERTUSSIS-TETANUS</b> (Primary series with booster in the last 10 years meets the requirement.)</p>	<p>Primary series of four doses with DtaP or DTP</p> <p>#1 _____ M D Y</p>	<p>DtaP/DTP</p> <p>#2 _____ M D Y</p>	<p>DtaP/DTP</p> <p>#3 _____ M D Y</p>	<p>DtaP/DTP</p> <p>#4 _____ M D Y</p>	<p>DtaP/DTP</p> <p>#5 _____ M D Y</p>	<p>Booster</p> <p>Tdap <input type="checkbox"/> Td <input type="checkbox"/></p> <p>_____  M D Y</p>
<p><b>HEPATITIS B</b> (Three doses of vaccine or a positive Hepatitis surface antibody meets the requirement.)</p>	<p>#1 _____ M D Y</p>	<p>#2 _____ M D Y</p>	<p>#3 _____ M D Y</p>	<p>Results: Reactive</p> <p>_____  M D Y</p>	<p>Results: Non-reactive</p> <p>_____  M D Y</p>	
<p><b>MENINGOCOCCAL MENINGITIS A, C, Y, W-135</b> Students will be removed from classes if vaccine is not completed within 30 days of arrival to Campus. The Clarke Health Center will administer vaccine for \$100 upon request.</p>	<p>One dose of either</p> <p>Menactra <input type="checkbox"/> Menovac <input type="checkbox"/> Menomune <input type="checkbox"/></p> <p>_____  M D Y</p>					
<p><b>MMR (Measles, Mumps, Rubella)</b> (Two doses required after 12 months of age *Students will be removed from classes if not completed in 30 days. (New York State Public Health Law)</p>	<p>Dose 1 given at age 12 months or later</p> <p>_____  M D Y</p>	<p>Dose 2 given at age 4-6 years or later, and at least one month after first dose</p> <p>_____  M D Y</p>				
<p><b>POLIO</b> (Primary series in childhood meets requirement; three primary series schedules are acceptable.)</p>	<p>OPV or IPV</p> <p>#1 _____ M D Y</p>	<p>OPV or IPV</p> <p>#2 _____ M D Y</p>	<p>OPV or IPV</p> <p>#3 _____ M D Y</p>	<p>OPV or IPV</p> <p>#4 _____ M D Y</p>		
<p><b>TUBERCULOSIS SCREENING</b> (Required within last 6 months, regardless of prior BCG.) (*If positive PPD see below)</p>	<p>Date given:</p> <p>_____  M D Y</p>	<p>Date Read:</p> <p>_____  M D Y</p>	<p>mm induration _____mm</p>	<p>BCG Date</p> <p>_____  M D Y</p>		
<p>If positive PPD, Chest X-ray report and doctor's examination in English to be attached</p>	<p>Chest X-ray</p> <p><input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</p> <p>_____  M D Y</p>	<p>Exam</p> <p><input type="checkbox"/> No signs of active TB <input type="checkbox"/> Active TB signs present</p>	<p>The World Health Organization and the Center of Disease Control recommend anti-TB therapy for Latent TB</p>	<p><input type="checkbox"/> The student is aware of the WHO and CDC guidelines and rationale, but refuses treatment <input type="checkbox"/> The student agrees to start treatment on: Date: _____ <input type="checkbox"/> The student completed treatment on _____  M D Y</p>		
<p><b>VARICELLA</b> (History and date of chicken pox, a positive Varicella antibody, or two doses of vaccine given at least one month apart if immunized after age 13 years meets the requirement.)</p>	<p>Documented Date of Disease</p> <p>_____ or _____  M D Y</p>	<p>Positive Antibody Titer or</p> <p>_____  M D Y</p>	<p>1<sup>st</sup> Date of Vaccine</p> <p>#1 _____  M D Y</p>	<p>2<sup>nd</sup> Date of Vaccine</p> <p>#2 _____  M D Y</p>		

**HEALTH CARE PROVIDER**

SIGNATURE \_\_\_\_\_ ADDRESS OR STAMP \_\_\_\_\_

NAME (PLEASE PRINT) \_\_\_\_\_ PHONE WITH AREA CODE \_\_\_\_\_