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. 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 effective medical care.

NAME AND CLASS YEAR:________________________ BIRTHDATE:________________________

HOME ADDRESS:________________________ HOME PHONE:________________________

________________________ CELL PHONE:________________________

City State Zip

E-MAIL:________________________

FULL NAME OF PARENT OR GUARDIAN:________________________

E-MAIL: ________________________

NAME OF PERSON TO NOTIFY IN CASE OF EMERGENCY:________________________

RELATIONSHIP TO STUDENT: ________________________ TELEPHONE: (H) ________________________

ADDRESS:________________________ (W) ________________________

________________________ (C) ________________________

City State Zip

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

☐ I will purchase insurance through the school.

NAME OF CURRENT HEALTH INSURANCE COMPANY: ________________________

SUBSCRIBER'S NAME & PLACE OF EMPLOYMENT: ________________________ SSN: ________________________

INSURANCE COMPANY ADDRESS: ________________________

City State Zip

CONTRACT NO.:________________________ GROUP NO.:________________________

Many insurance companies require prior approval before obtaining services rendered outside the Clarke Health Center. (throat and urine cultures, bloodwork, x-rays or referral)

- Please contact your insurance company to know what needs to be done and communicate this information to your student prior to arrival to campus.
- **Prior approvals and arrangements will be the student's responsibility.**

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):________________

STUDENT'S NAME: ______________________ CLASS YEAR __________ D.O.B. ______________

FAMILY MEDICAL HISTORY:

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

_____ Alcoholism
_____ Anemia
_____ Anxiety
_____ Bleeding Tendency
_____ Breast Cancer prior to menopause
_____ Cancer
_____ Depression
_____ Diabetes
_____ Dilated Cardiomyopathy
_____ Heart Disease
_____ Hereditary Disorder: ______________
_____ High Blood Pressure
_____ Hypertrophic Cardiomyopathy
_____ Long QT Syndrome
_____ Marfan's Syndrome
_____ Mental Illness
_____ Obesity
_____ Premature death or morbidity from cardio-vascular disease at younger than 50
_____ Sickle Cell Trait
_____ Stroke
_____ Tuberculosis

STUDENT MEDICAL HISTORY: Check any that apply:

_____ ADD _____ ADHD
Testing date: ______________
(for ADA accomodations, testing needs to be within 3 years of arrival to campus)
_____ Allergic Rhinitis
_____ Allergy Shots
_____ Anxiety
_____ Asthma
_____ Blood Abnormality (Anemia, Bleeding Trait, Sickle Cell)
_____ Cancer or Malignancy
_____ Chicken Pox: Date: ______________
_____ Concussion(s): Number: ______________
_____ Counseling
_____ Depression
_____ Diabetes
_____ Eating Disorders
_____ Excessive unexplained shortness of breath, chest pain or fatigue with exercise
_____ Fractures
_____ Hypertension (Elevated Blood Pressure)
_____ Ileitis-Colitis
_____ Knee Injury
_____ Menstrual Problems
_____ Migraine Headaches
_____ **Mono**nucleosis
_____ Pelvic Infection
_____ Peptic Ulcer
_____ Pregnancies
_____ Psychiatric Hospitalization
_____ Psychiatric Illness
_____ Recurrent Ear Infections
_____ Rheumatic Fever
_____ Seizure Disorders (Epilepsy)
_____ Sexually Transmitted Infection
_____ Sleeping Issues ______________
_____ Substance or Alcohol Abuse
_____ Suicide Attempt
_____ Surgeries (please list): ______________
____
____
_____ Tuberculosis or past positive TB test
_____ Urinary Tract Infections
_____ Viral Hepatitis
_____ Prior dizziness or fainting with exercise
_____ Prior history of heart murmur or increased blood pressure other than resolved functional murmur. Please send copy of EKG and Echo Report.
_____ Other: ______________
_____ **None Apply**

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

Vision: ______________
Hearing: ______________
Mobility: ______________
Other motor: ______________
Emotional: ______________
Learning: ______________
ADD/ADHD: ______________
Other: ______________

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 Personally Identifiable Information (PII) and 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 Date

____
Signature of Parent or Guardian if Student under 18

____
Printed Name of Student Representative (if applicable)

____
Relationship to Student

PHYSICAL EXAMINATION • Please fill out completely.

We require that the physical be done **within one year prior to arrival to campus** by a health care provider 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:

CLINICAL EVALUATION FOR ALL STUDENTS (***NCAA** and Elmira College require cardiac pre-screening, sickle cell trait screening, and ADD/ADHD testing if applicable for athletic participation.) **Check each item in proper column.**	NORMAL	ABNORMAL	Note: Give details of each abnormality with corresponding item number
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 (strength, range of motion)			
15. Spine, other Musculo-skeletal			
16. Skin and Lymphatics			
17. Neurologic			
18. Psychiatric (specify any personality deviations)			
19. Recognition of Marfan's Syndrome			
20. Hearing			
21. Vision			

PLEASE LIST ANY PRESCRIPTION MEDICATION: ____

____

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 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

STUDENT'S NAME: ____ CLASS YEAR __________ D.O.B. ____________________

IMMUNIZATION RECORD

Mandatory						
MMR Measles, Mumps, Rubella (Students will be removed from classes if vaccines are not completed within 30 days of arrival to Campus as per New York State Public Health Law Section 2165.)	Dose I given at age 12 months or later ____-___-____ M D Y	Dose 2 given at age 4-6 years or later, and at least one month after first dose or ____-___-____ M D Y	Date of positive titers acceptable ____-___-____ M D Y	Provide copy of positive titers if drawn		
MENINGOCOCCAL MENINGITIS A, C, Y, W- 135 (Students will be removed from classes if vaccine is not completed within 30 days of arrival to Campus as per New York State Public Health Law Section 2167.)	One dose of either Menactra ❑ Menveo ❑ Menomune ❑ ____-____-____ M D Y	Booster if 1st dose before age 16 Menactra ❑ Menveo ❑ Menomune ❑ ____-____-____ M D Y	The Clarke Health Center will administer vaccine for $100 upon request			

Strongly Recommended						
DIPTHERIA-PERTUSSIS-TETANUS (Primary series with booster in the last 10 years meets the requirement. A minimum of three vaccines)	Primary series of four doses with DtaP or DTP #1 ___-____-____ M D Y	#2____-____-____ M D Y	DtaP/DTP #3____-____-____ M D Y	DtaP/DTP #4____-____-____ M D Y	DtaP/DTP #5___-____-___ M D Y	Booster Tdap ❑ Td ❑ ____-___-____ M D Y
HEPATITIS B (Three doses of vaccine or a positive Hepatitis surface antibody meets the requirement.)	DtaP/DTP #1____-____-____ M D Y	#2 ____-____-____ M D Y	#3____-____-____ M D Y	Results: Reactive ____-____-____ M D Y	Results: Non-reactive ____-____-____ M D Y	Provide copy of positive titers if drawn
POLIO (Primary series in childood meets requirement; three primary series schedules are acceptable.)	OPV or IPV #1____-____-____ M D Y	OPV or IPV #2____-____-____ M D Y	OPV or IPV #3____-____-____ M D Y	OPV or IPV or #4____-____-____ M D Y	Positive titer ____-____-____ M D Y	Provide copy of positive titers if drawn
VARICELLA (History and date of chicken pox, a positive Varicella antibody, or two doses of vaccine given at least one month apart.)	Documented Date of Disease or ____-____-____or M D Y	1st Date of Vaccine #1 ___-____-____ M D Y	2nd Date of Vaccine or #2____-____-____ M D Y	Positive Antibody Titer ____-____-____ M D Y	Provide copy of positive titers if drawn	
TUBERCULOSIS SCREENING (Required within last 6 months, regardless of prior BCG.) (*If positive PPD see below)	Date given: ____-____-____ M D Y	Date Read: ____-____-____ M D Y	mm induration ______mm	BCG Date ____-____-____ M D Y		
If positive PPD, Chest X-ray report and doctor's examination in English to be attached	Chest X-ray ❑ Normal ❑ Abnormal ____-____-____ M D Y	Exam ❑ No signs of active TB ❑ Active TB signs present	The World Health Organization and the Center of Disease Control recommend anti-TB therapy for Latent TB	❑ The student is aware of the WHO and CDC guidelines and rationale, but refuses treatment ❑ The student agrees to start treatment on: Date: ________________ ❑ The student completed treatment on ____-____-____ M D Y		

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