



NAME _____ SOC. SEC. # _____
 LAST FIRST MI

HOME ADDRESS _____
 STREET CITY STATE ZIP

LOCAL ADDRESS _____
 STREET CITY STATE ZIP

HOME PHONE NO. () _____ LOCAL PHONE NO. () _____

PREVIOUS NAME _____ M ___ F ___ DATE OF BIRTH _____

PERSON TO NOTIFY IN EMERGENCY _____

HOME PHONE NO. () _____ BUSINESS PHONE NO. () _____

INSURANCE CARRIER _____ POLICY # _____

**HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?
 CHECK ALL THAT APPLY**

ARTHRITIS	EPILEPSY	MALIGNANCY
ASTHMA	EYE INJURY	MUMPS
BACK TROUBLE	FREQUENT FAINTING	RHEUMATIC FEVER
CHICKEN POX	HEARING IMPAIRMENT	SKIN DISEASE
CHRONIC COUGH	HEART/CIRCULATION	SPEECH DEFECT
CHRONIC DIARRHEA	HEPATITIS	THYROID DISORDER
DIABETES	HERNIA	TUBERCULOSIS
EATING DISORDER	HIGH BLOOD PRESSURE	ULCER
ANOREXIA / BULIMIA	KIDNEY DISEASE	URINARY PROBLEM
EMOTIONAL DISORDER	KNEE TROUBLE	VISION IMPAIRMENT
MOBILITY ASSISTANCE	HEAD INJURY	LEARNING DISABILITY
NEUROLOGICALLY IMPAIRED		

PLEASE EXPLAIN ANY OF THE ABOVE AND OTHER DISEASES OR DISABILITY: _____

PRESENT MEDICATIONS: _____

OPERATIONS OR SEVERE INJURIES: _____

HAVE YOU BEEN TREATED FOR DRUG OR ALCOHOL PROBLEMS? YES _____ NO _____ EXPLAIN: _____

LIST ANY ALLERGIES: _____

MAY WE INFORM YOUR INSTRUCTORS OF YOUR STATUS: YES _____ NO _____

DO YOU REQUIRE EVACUATION ASSISTANCE IN THE EVENT OF A FIRE OR OTHER EMERGENCY?
 YES _____ NO _____

STUDENT SIGNATURE _____ DATE _____

****PLEASE FILL OUT THIS SIDE COMPLETELY AND HAVE YOUR PHYSICIAN OR HEALTHCARE PROVIDER COMPLETE THE OTHER SIDE OF THIS FORM****

****PLEASE HAVE YOUR PHYSICIAN OR HEALTHCARE PROVIDER COMPLETE THIS SIDE OF FORM****

IMMUNIZATION RECORDS

PLEASE LIST VACCINE DATES FOR THE FOLLOWING:

*****NEW YORK STATE LAW REQUIRES TWO MEASLES IMMUNIZATIONS, ONE MUMPS AND ONE RUBELLA
THE LAW APPLIES TO ALL STUDENTS BORN AFTER JANUARY 1, 1957.**

	VACCINE DATE	SEROLOGY DATE / RESULTS	COMBINED MMR
MEASLES			DATE OF #1
MUMPS			DATE OF #2
RUBELLA			

*****TUBERCULOSIS TEST: GIVEN IN THE U.S. WITHIN 3 MONTHS OF COLLEGE ENTRY.**

TUBERCULOSIS TEST: PPD OR MANTOUX	DATE:	RESULTS:	IF POSITIVE, CHEST X-RAY DATE : RESULTS:
HEPATITIS B VACCINE	DATE OF #1:	DATE OF #2:	DATE OF #3:
TD – BOOSTER	DATE:		

*****NEW MENINGITIS LAW: ALL COLLEGE STUDENTS MUST BE AWARE OF THE MENINGITIS DISEASE OR
RECEIVE THE VACCINE, PLEASE SEE THE ENCLOSED INFORMATION SHEET AND RESPONSE FORM.**

MENINGOCOCCAL VACCINE	DATE:
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*****PLEASE FILL OUT THE ATTACHED RESPONSE FORM, CHECK THE APPROPRIATE BOX AND RETURN
BOTH FORMS TO THE HEALTH OFFICE.**

I CERTIFY THAT THE ABOVE IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

DOCTOR / HEALTH CARE PROVIDER SIGNATURE

DATE

*****PHYSICAL EXAMINATION***
(MUST BE GIVEN AFTER JUNE 15, 2006, IF PLAYING A SPORT)**

DATE OF EXAMINATION: _____

BLOOD PRESSURE /	PULSE:	RESP:
HEART:	LUNGS:	HERNIA:
ABDOMEN:	WEIGHT:	HEIGHT:

OTHER COMMENTS: _____

FOLLOW UP RECOMMENDED? YES _____ NO _____

THIS STUDENT IS ABLE TO PARTICIPATE IN INTERCOLLEGIATE ATHLETICS AND/OR PHYSICAL EDUCATION
CLASSES: YES _____ NO _____

PHYSICIANS NAME (please print) _____

PHYSICIANS SIGNATURE _____

ADDRESS _____ PHONE NUMBER () _____