MORRISVILLE STATE COLLEGE
MATTHIAS STUDENT HEALTH CENTER

PO BOX 901
MORRISVILLE, NY 13408
PHONE (315) 684-6078 FAX (315) 684-6493

Welcome to Morrisville State College. Your health history is an important part of the care we will provide to you while you are a student. ***Please fill out all sections on pages 1 & 2*** *and then your Health Care Provider needs to complete the Immunization and Physical Exam form on pages 3 & 4.* ***PLEASE BE SURE THAT YOUR NAME IS WRITTEN ON THE TOP OF EACH PAGE (1-4) OF THIS FORM****. Thank You. Please refer to the enclosed Welcome Letter for further information.*

NAME AND ADDRESS *PLEASE PRINT*			DATE
Last Name, First Name, MI			College ID # or Social Security Number
Street Address/PO Box/Apt.#	City	State	ZIP
Telephone	Date of Birth	Age	Gender ☐ Male ☐Female

EMERGENCY CONTACTS (PERSONS TO BE CONTACTED IN CASE OF EMERGENCY) Please list *two* contacts		
1. Name	Relationship	Home Phone
Address		Business Phone
2. Name	Relationship	Home Phone
Address		Business Phone

PRIMARY CARE PHYSICIAN	Phone
Address	Fax

HEALTH INSURANCE: A copy of your insurance information is *required* for your health record. It would be beneficial for you to have your own card or a copy in your possession while at college.

Please photocopy **FRONT** and **BACK** of your insurance card and attach here

OR

Please check here if you will be purchasing Student Health Insurance. ☐

STUDENT LAST NAME ______ FIRST ______ MI ______

ATTENTION STUDENTS *UNDER EIGHTEEN* (18)

In order to procure quickly any emergency care that may be necessary for students and at the same time to protect the physicians and institutions involved, it is required that **you sign and have notarized** the consent for emergency treatment below.

I ____ do hereby authorize the Medical staff of Morrisville State College
PARENT/GUARDIAN *PLEASE PRINT NAME*
upon consultation with a practicing physician or surgeon to exercise for me and on my behalf, all rights and duties with reference to consenting to appropriate medical, psychiatric, and surgical treatment, anesthetics, medicines and hospitalization, including care and treatment by any hospital, staff surgeon, physician or radiologist which they may deem necessary for the emergency care of my son/daughter ____.
PRINTED FULL NAME OF STUDENT STUDENT'S DATE OF BIRTH

PARENT/GUARDIAN SIGNATURE____ DATE______________________________

SUBSCRIBED BEFORE ME THIS ______DAY OF ______________________________, 20____. NOTARY STAMP/SEAL

PLEASE COMPLETE THIS SECTION BEFORE GOING TO YOUR HEALTH CARE PROVIDER FOR EXAMINATION (please print).

PERSONAL MEDICAL HISTORY

HAVE YOU HAD?	Yes		Yes		Yes	**FAMILY MEDICAL HISTORY**	Yes	Relationship
Measles		Head Injury w/ unconsciousness		Hepatitis		Diabetes		
German Measles		**SURGERY**		Stomach or Intestinal Trouble		Kidney Disease		
Mumps		Appendectomy		Gallbladder		Heart Disease		
Chicken Pox		Tonsillectomy		Recurrent Diarrhea		High blood pressure		
Malaria		Hernia Repair		Hernia		Cancer		
Tuberculosis		Other (describe below in comments)		Acne (on medication)		Epilepsy/Seizures		
Mononucleosis		Seizures		Urine Infection		Other		
Gum/Tooth Trouble		Weakness/Paralysis		Diabetes				
Eye Trouble		Shortness of Breath		Disease/Injury of Joints				
Ear Infections		Seasonal Allergies		Back Problems				
Throat Infections		Asthma		Tumor/Cancer (explain below)				
Insomnia		Palpitations (Heart)		Recent Weight Gain or Loss				
Anxiety/Depression		High Blood Pressure		**FEMALES ONLY:**				
Fainting Spells		Heart Murmur		Irregular Periods				
Migraines		Rheumatic Fever						

COMMENTS:

____

____

____

____

STUDENT LAST NAME ______ FIRST ______ MI ______

THIS SECTION IS TO BE COMPLETED BY HEALTH CARE PROVIDER

REQUIRED IMMUNIZATIONS

Students with incomplete immunization records will NOT be able to obtain grades and will be ineligible to register for a second semester.

MMR	**First Dose**	**Second Dose**
Measles,Mumps,Rubella	________ mo/da/yr	________ mo/da/yr

IF BORN AFTER 1956, TWO DOSES OF LIVE VIRUS MEASLES VACCINE, OR MMR, THE FIRST DOSE AT 12 MONTHS OF AGE OR LATER AND THE SECOND DOSE AT LEAST ONE MONTH LATER. PERSONS BORN BEFORE 1957 ARE EXEMPT DUE TO NATURAL IMMUNITY FROM THE DISEASE.

OR

2 doses **Measles** 1st__________ (month/day/yr) 2nd __________ (month/day/yr) 1 dose **Mumps** __________ (month/day/yr) 1 dose **Rubella** __________ (month/day/yr)

OR

Serologic evidence (blood work) of immunity to each. **Lab work must be submitted with physical.**

MENINGITIS ______________ □ I have received the meningitis vaccine. Please circle one: Menomune Menactra **OR**

SEE MENINGITIS WAIVER FORM BELOW

MENINGITIS WAIVER REQUIRED IF DOCUMENTATION OF VACCINATION NOT PROVIDED

Waiver: I have reviewed the enclosed Fact Sheet regarding meningococcal disease. I am fully aware of the risks associated with this disease and of the availability and effectiveness of the vaccine. I have elected NOT to get the vaccine.

Signature of Student (or parent/guardian if under 18)

____ Date______________

RECOMMENDED IMMUNIZATIONS

PPD (Mantoux) within 6 months of admission to college ______________ (Date Administered) ____________ (Date Interpreted) __________ (Result) mm induration

If currently positive or prior history of positive PPD, chest x-ray report (in ENGLISH and done within 6 months of admission),with date and result must be submitted with physical.

TETANUS (Td) **W**ithin 10 years of admission to college ___________ (month/day/yr)

HEPATITIS B #1___________ #2___________ #3___________

OR

HEPATITIS B 2 Shot Series #1___________ #2___________

VARICELLA __history of chicken-pox disease please check **OR** #1___________ #2___________ (*Required if given at age 13 or older*)

OR Titer (include lab report) ______________________

COLLEGE USE ONLY	
Reviewed by	Date entered
Fall 20___	Spring 20___

____
SIGNATURE/MEDICAL PROFESSIONAL CERTIFYING ABOVE IMMUNIZATION RECORD

STUDENT LAST NAME ______ FIRST ______ MI ______

SECTION BELOW TO BE COMPLETED BY PHYSICIAN/NP/PA

PHYSICAL EXAMINATION

Must be completed not more than one year prior to the start of the semester.

Ht.______Wt.______BP______Pulse______ Build: □ Slender □ Med. □ Heavy □ Obese

CLINICAL EXAMINATION			
Check each item in proper column; Enter NE if not evaluated.	Normal	Abnormal	If abnormalities are noted, please describe
Neck			
HEENT			
Lungs, chest and breasts			
Heart (include any murmur/defect)			
Abdomen (include hernia)			
Genitalia			
Musculoskeletal/Extremities			
Skin			
Neurologic			
Psychiatric			

Lab tests at discretion of physician (please enclose copy of any labs ordered)

Is this student able to participate in all sports/physical activity? □ Yes □ No If "NO," what activities are to be eliminated? ______________________________

Do you recommend further investigation or treatment? □ No □ Yes (Please explain "yes")

____

ALLERGY TO: (Please circle Yes or No)

Medication No Yes (Pleaselist)______________________________

Insect bites/bee stings No Yes

Foods No Yes (Please list) ______________________________

Other Yes Please explain ______________________________

Does patient carry an Epi-pen? Yes No

CURRENT MEDICATIONS: Please list any prescription, over the counter, herbal medications, birth control pills:

Name Dose Reason for Taking

____

____

____

Name of examining Physician/NP/PA			Date of PE
Street	City	State	Zip code
Signature		Area code and phone #	

Please return completed form (with student name filled in above) to:

Morrisville State College

Matthias Student Health Center

Phone (315) 684-6078 Morrisville, NY 13408 Fax (315) 684-6493

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