Canisius COLLEGE
Where leaders are made

2012-2013 Physical Examination and Immunization Form For International Students Only

Canisius College Student Health Center
2001 Main Street
Buffalo, NY 14208
Phone: 716-888-2610
Fax: 716-888-3217
canisius.edu/student_health

All students must submit this completed form in English to Student Health. NO OTHER FORM WILL BE ACCEPTED.
Incomplete or overdue forms will stop or delay registration.
For fall 2012 attendance, form must be submitted by July 31, 2012. For spring 2013 attendance, form must be submitted by January 1, 2013.
For non athletes, physical examinations must be done within the past **12 months**. For intercollegiate Division I athletes, physical examinations must be done within **6 months** of sports participation. Failure to complete or submit this form will stop registration and prevent sports participation.
*Please record all dates as month/day/year (mm/dd/yy).

Last Name | First Name | Middle Initial

Month | Day | Year — Date of Birth | Student ID | ☐ Male ☐ Female — Gender | E-mail address

Permanent Address | City | Country | Postal Code

Country code, city code, Phone | Country code Cell Phone | Citizenship

Emergency Contact - this is the person we will contact in the event you have a medical emergency at school

Emergency Contact – name/relationship | Country code, city code Phone | Cell Phone | Work Phone

Emergency Contact Address | City | Country | Postal Code | E-Mail Address

Personal Physician

Personal Physician | Address | Phone | Fax

PLEASE DO NOT PURCHASE AN ALTERNATE HEALTH INSURANCE PLAN
All international students must purchase the health insurance plan offered through Canisius College.

MENINGITIS RESPONSE: IMPORTANT – THIS RESPONSE IS REQUIRED BY NEW YORK STATE LAW FOR ALL STUDENTS.

☐ Date of meningococcal immunization containing serogroups A, C, Y, W-135 within the past 10 years.

Month Day Year

☐ I read 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 (my child) will **not** obtain the immunization against meningococcal meningitis disease.

Signature of Student (Required) | **Date (mm/dd/yy)**

Signature of Parent/Guardian for minor (Required) | **Date (mm/dd/yy)**

Consent to Treat and Attestation. Without signatures Student Health cannot treat this student.Parent/Guardian must sign for student under 18 years of age.
I authorize the Canisius College Student Health Center to provide care and treatment to me (my child/legal ward) as deemed appropriate. This includes but is not limited to routine, urgent, emergency care, medication, immunization, diagnostic studies and referrals to hospitals, clinics and/or medical specialists deemed necessary by the college's medical and/or nursing staff. In the event of a life threatening emergency or serious illness/injury of which the Student Health Center is aware, I authorize the Student Health Center or college designee to notify my emergency contact. I verify that all medical and psychological information I have provided is complete and accurate. I will notify the Student Health Center hereafter of any changes in my health that occur while a student at Canisius College.

Signature of Student (Required) | **Date (mm/dd/yy)**

Signature of Parent/Guardian for minor (Required) | **Date (mm/dd/yy)**

Medical History

Please check box if you have ever had any of the following conditions.

Name of Student _____ Date of Birth Month Day Year

Infectious Disease
- ☐ Chicken Pox
- ☐ Infectious Mononucleosis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Tuberculosis
- ☐ Malaria

Eyes, Ears, Nose, Throat
- ☐ Wear glasses/contact
- ☐ Other Visual problems
- ☐ Hearing Loss/Deafness
- ☐ Seasonal Allergies
- ☐ Recurrent Sinus Infection
- ☐ Recurrent Ear Infection
- ☐ Recurrent Nose Bleeds

Cardiopulmonary
- ☐ Chest pain with exercise or exertion
- ☐ Syncope or Near Syncope
- ☐ Excessive exertional or unexplained shortness of breath with exercise
- ☐ Excessive exertional or unexplained fatigue with exercise
- ☐ Heart Murmur
- ☐ Elevated blood pressure
- ☐ Mitral Valve Prolapse
- ☐ Rheumatic Heart Disease
- ☐ Heart Palpitations or Irregular beat
- ☐ Elevated cholesterol
- ☐ Marfan Syndrome
- ☐ Congenital Heart Defect
- ☐ Asthma
- ☐ Pneumonia/Bronchitis

G-I
- ☐ Reflux/GERD
- ☐ Ulcer
- ☐ Pancreatitis
- ☐ Gall Bladder Disease
- ☐ Hepatitis Type: _____
- ☐ Hernia
- ☐ Rectal Bleeding
- ☐ Irritable Bowel
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Hemorrhoids

Genitourinary
- ☐ Cystitis/Bladder Infection
- ☐ Blood in Urine
- ☐ Kidney Infection
- ☐ Chronic Kidney Disease
- ☐ Kidney Stones
- ☐ Sexually Transmitted Disease

Female
- ☐ Pelvic/Vaginal Infections
- ☐ Pregnancy
- ☐ Breast Lump
- ☐ Painful periods
- ☐ Irregular periods
- ☐ Heavy flow
- ☐ Abnormal PAP smear

Male
- ☐ Testicular Lump
- ☐ Testicular Torsion
- ☐ Undescended/absent testicle
- ☐ Hydrocele or Varicocele

Musculoskeletal
- ☐ Arthritis
- ☐ Joint Injury
- ☐ Bone Fractures
- ☐ Scoliosis
- ☐ Back Pain/Problems
- ☐ Osgood-Schlatter
- ☐ Tendinitis
- ☐ Other Musculoskeletal Disorders

Hematologic/Oncologic
- ☐ Anemia
- ☐ Sickle Cell trait/disease
- ☐ Leukemia/Lymphoma
- ☐ Hemophilia
- ☐ Immune Deficiency
- ☐ Cancer

Neurologic
- ☐ ADD/ADHD
- ☐ Seizure Disorder
- ☐ Migraine Headaches
- ☐ Tension Headaches
- ☐ Concussion
- ☐ Head Injury with Loss of Consciousness
- ☐ Other Neurological Disorders

Skin
- ☐ Eczema
- ☐ Acne
- ☐ Hives
- ☐ Chronic rash
- ☐ Tattoos/ Piercings
- ☐ Other: _____

Metabolic
- ☐ Diabetes Mellitus
- ☐ Thyroid Disorder

Mental/Emotional
- ☐ Anger Management
- ☐ Eating Disorder
- ☐ Drug/Alcohol Dependency/Abuse
- ☐ Depression
- ☐ Panic/Anxiety Disorder
- ☐ Trouble sleeping
- ☐ Bipolar Disorder
- ☐ Mood Disorder
- ☐ Obsessive Compulsive Disorder
- ☐ Schizophrenia
- ☐ Deliberate self harm
- ☐ Previous psychiatric hospitalization
- ☐ Other: _____

Other
- ☐ Anaphylactic Reaction
- ☐ Serious Accident/Injury
- ☐ Loss of paired organ:
  - ☐ Kidney
  - ☐ Ovary
  - ☐ Eye
  - ☐ Testicle
  - ☐ Other: _____
- ☐ Other important medical history:

_____

_____

Do you use tobacco?
☐ No ☐ Yes – packs/day_____

Do you drink alcohol?
☐ No ☐ Yes – amount/week_____

Allergies: ☐ None
- ☐ Allergic to medications
- ☐ Allergic to X-ray dyes
- ☐ Allergic to food/insects/ environmental

Please list all:

_____

_____

_____

Surgeries: ☐ None
- ☐ Appendectomy ☐ Hernia repair
- ☐ Mole Removal ☐ Ear Tubes
- ☐ Wisdom Teeth Extraction
- ☐ Tonsils/Adenoids
- ☐ Other: (specify below)

_____

_____

_____

Medications (including vitamins and supplements): ☐ None

_____

_____

_____

_____

_____

_____

Additional information you wish to share about your health:

_____

_____

_____

_____

_____

_____

Family History

	Age	State of Health	If Deceased, Age of Death	Cause of Death
Father				
Mother				
Siblings				

Have any of your relatives ever had any of the following?	Yes	Relationship		Yes	Relationship
Alcoholism			Cancer		
Asthma, Hay Fever			Mental Illness		
Diabetes			Kidney Disease		
Sickle Cell Trait/Disease			Seizure Disorder		
Disability due to heart disease before age 50			Marfan syndrome		
Elevated Blood Pressure			Other (list):		
Other heart related diagnosis, cardiomyopathies, long QT syndrome, arrhythmias					

Immunizations | Healthcare Provider: complete in English and sign at the bottom of this page.

*** No other immunization documents will be accepted. Record vaccination date as month/day/year (mm/dd/yy).**

| Name of Student | Date of Birth (Month / Day / Year)

MMR (Measles, Mumps, Rubella)	If born on or after 1/1/57, two doses of live MMR vaccine required. **Dose #1** administered on or after 1st birthday. **Dose #2** administered after 15 months of age and at least 28 days after 1st dose.	**Dose #1** __ / __ / __ (MM DD YY)	**Dose #2** __ / __ / __ (MM DD YY)		
Measles	If born on or after 1/1/57, two live doses required. **Dose #1** administered on or after 1st birthday. **Dose #2** administered after 15 months of age and at least 28 days after 1st dose.	**Dose #1** __ / __ / __ (MM DD YY)	**Dose #2** __ / __ / __ (MM DD YY)	**Disease date** __ / __ / __ (MM DD YY)	**Serology date** __ / __ / __ (MM DD YY) ☐ **Immune**
Mumps	If born on or after 1/1/57, one live dose required. **Dose #1** administered on or after 1st birthday.	**Dose #1** __ / __ / __ (MM DD YY)	**Disease date** __ / __ / __ (MM DD YY)	**Serology date** __ / __ / __ (MM DD YY) ☐ **Immune**	
Rubella	If born on or after 1/1/57, one live dose required. **Dose #1** administered on or after 1st birthday.	**Dose #1** __ / __ / __ (MM DD YY)	**Serology date** __ / __ / __ (MM DD YY) ☐ **Immune**		
Meningococcal Vaccine	One dose within past 10 years containing serogroups A, C, Y, W-135	**Dose #1** __ / __ / __ (MM DD YY)	**Dose #2** __ / __ / __ (MM DD YY)		
Varicella Vaccine	Two doses, disease date or serology.	**Dose #1** __ / __ / __ (MM DD YY)	**Dose #2** __ / __ / __ (MM DD YY)	**Disease date** __ / __ / __ (MM DD YY)	**Serology date** __ / __ / __ (MM DD YY) ☐ **Immune**
Tetanus, Diptheria Pertussis	One booster within last 10 years. A single dose of Tdap recommended for all students. Please specify:	☐ Tdap __ / __ / __ (MM DD YY)	☐ **Td** __ / __ / __ (MM DD YY)		
Polio Vaccine	Date primary series completed.	__ / __ / __ (MM DD YY)			
Hepatitis B Vaccine	Series of 3 doses.	**Dose #1** __ / __ / __ (MM DD YY)	**Dose #2** __ / __ / __ (MM DD YY)	**Dose #3** __ / __ / __ (MM DD YY)	
Hepatitis A Vaccine	Series of 2 doses.	**Dose #1** __ / __ / __ (MM DD YY)	**Dose #2** __ / __ / __ (MM DD YY)		
HPV	Series of 3 doses.	**Dose #1** __ / __ / __ (MM DD YY)	**Dose #2** __ / __ / __ (MM DD YY)	**Dose #3** __ / __ / __ (MM DD YY)	
BCG Vaccination		__ / __ / __ (MM DD YY)			

TUBERCULOSIS (TB) Screen - Required for all students.

1. Does the student have signs or symptoms of active TB disease ☐ Yes (go to TB Test) ☐ No (go to question 2)
2. Is the student a member of a high risk group,* or an international student from a high risk country.**
   ☐ Yes (go to TB Test) ☐ No (**STOP.** No further screening needed)

TB Test (MUST BE DONE WITHIN 6 MONTHS OF ATTENDING CANISIUS COLLEGE):

Tuberculin Skin Test: (Mantoux only)
Date placed: ___/___/___ (MM DD YY) Date read: ___/___/___ (MM DD YY)
Result:_____ mm of induration
Interpretation based on mm of induration and risk factors:
☐ Negative ☐ Positive (Chest X-ray required)

OR

IGRA (specify method) ☐ QFT-G ☐ QFT-GIT ☐ T-SPOT
Date Tested ___/___/___ (MM DD YY)
Result: ☐ Negative
☐ Indeterminate/borderline (repeat in 6-8 weeks)
☐ Positive (Chest X-Ray required)

Chest X-ray date: _____ /_____ /_____ (MM DD YY) Result: ☐ Normal ☐ Abnormal (explain): _____

Treatment Plan (include information about INH therapy and duration of treatment): _____

* High risk students include those with HIV, close contact of a perosn with infectious TB, inject drugs, resided in, volunteered in, or worked in prison/jail, nursing home or long term care facility, hospital or health care center, residential facility for AIDS patients, or homeless shelter or have diabetes, chronic renal failure, leukemia/lymphoma, low body weight (10% or more below ideal), gastrectomy, jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone ≥ 15 mg/d for ≥ 1 month) or other immuno-suppressive disorders.

**Categories of high risk students include those students who have arrived within the past 5 years from or traveled to countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Students should undergo TB screening if they have arrived from countries EXCEPT those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia, USA, Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia or New Zealand.

I verify that the immunization records and TB screen results are complete and accurate to the best of my knowledge.

| Signature of Health Care Provider

Physical Examination (PE) | **Healthcare Provider: complete in English, sign and date at bottom of page.**

*** No other form will be accepted**

Entering Fall 2012 PE must be done after August 27, 2011. Entering Spring 2013 PE must be done after January 14, 2012.

Name	Date of Birth (Month Day Year)	Gender ☐ Male ☐ Female

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

SICKLE CELL SCREEN REQUIRED FOR ALL D1 ATHLETES

Sickle Cell Screen Date: _____ /_____ /_____ ☐ Positive ☐ Negative
MM DD YY

Clinical Evaluation	Normal	Record Abnormal Findings
1. Appearance (Report evidence of Marfan Stigmata)		
2. Skin		
3. Head, Ears, Eyes, Nose, Hearing, Visual Acuity		
4. Mouth, Teeth, Gums		
5. Neck and Thyroid		
6. Lungs/Chest		
7. Breasts		
8. Heart (supine and standing)		
9. Pulses (simultaneous femoral and radial)		
10. Abdomen		
11. Genitalia		
12. Back/Spine		
13. Extremities/Musculoskeletal		
14. Neurologic		
15. Emotional/Psychological		
16. Paired Organ Anatomy/Function		
17. Other Findings		

18. Is this student cleared for full physical activity, including participation in intramural, club or intercollegiate sports and able to meet the physical and emotional demands of college life, including studying abroad?

☐ Yes/ Unlimited activity and fit for college ☐ No/Limited activity Reason: _____

Additional Comments/Recommendations: _____

I have reviewed the medical history, immunizations, TB Screen and examined the student noted above. The information on this physical form is accurate, full and complete to the best of my knowledge. (Please date your signature.)

Signature of Health Care Provider _____ Date (mm/dd/yy) _____

Print Name of Healthcare Provider _____ Address _____ Phone _____ Fax _____

Do not write below this line

Reviewed by: Initials _____ Date _____

☐ **Incomplete for:**

☐ **Immunizations**
☐ Measles ☐ Rubella
☐ Mumps ☐ Meningitis

☐ **PE**
☐ Medical History ☐ TB Screen/TSpot ☐ Date of PE
☐ Consent ☐ MD Signature ☐ Activity

Notified by: ☐ Letter ☐ E-mail ☐ Phone ☐ In-Person | Initials _____ Date_____

☐ **PE and Immunization Complete:**

Initials _____ Date _____