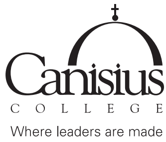

Physical Examination and Immunization Form for International Students

Must be completed in English and be legible.

No information regarding your past or present health status will be released to anyone without your written consent.
Physical exam must be given after March 1, 2008 and returned by August 25, 2008 for Fall 2008 attendance.
Physical exam must be given after August 1, 2008 and returned by January 12, 2009 for Spring 2009 attendance.
Return the completed form to: Canisius College Student Health Center, 2001 Main Street, Buffalo, NY 14208.
Incomplete or overdue forms will stop or delay registration.

Last Name | First Name | Middle Initial

Month | Day | Year — Date of Birth | Student ID | Gender: ☐ Male ☐ Female | Email Address

Permanent Address | Country Code, City Code | Mobile Phone Country Code

City or Town | Country | Postal Code | Citizenship

Emergency Contact Information

Emergency Contact – name and relationship | Country Code, City Code | Mobile Phone Country Code | Work Phone

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

Personal Physician

Primary Physician | Address | Phone | Fax

Meningitis Response: Important – This response is required by New York State law for all students.

☐ Date of meningococcal immunization (Menomune™ or Menactra™) within the past 10 years:

Month | Day | Year

☐ I have read or had explained to me the fact sheet enclosed regarding meningococcal disease and am declining the vaccine at this time. I am fully aware of the risks associated with this disease, and of the availability and effectiveness of the of vaccine.

Signature of Student (or parent/guardian if student under 18) | Date – Month / Day / Year

Medical Care Authorization for Minors (without parent/guardian signature the Student Health Center cannot treat this student)

I authorize the Student Health Center at Canisius College to provide care and treatment to my child/legal ward. I give permission for treatment that may include, but is not limited to, routine, urgent and emergency care, medicines, immunizations, laboratory, diagnostic studies, referral to hospitals, clinics or medical specialist deemed necessary by the college's medical and nursing staff.

I hearby authorize any physician, health care institution, or other healthcare providers with whom the Student Health Center staff deems appropriate to consult, to provide my child or legal ward emergency medical care, routine care, and urgent care; including, without limitation, general medical care, psychiatric care, surgery, anesthesia, radiology, medicines, immunizations, or hospitalization.

Signature of Parent/Guardian | Date – Month / Day / Year

Medical History | **Student to complete in English and sign.**

Please check box if you have ever had or are currently under treatment for any of the following. Please explain all checked items in section below.

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
- ☐ Shortness of Breath with Exercise
- ☐ Fatigue with Exercise
- ☐ Asthma
- ☐ Pneumonia/Bronchitis
- ☐ Marfan Syndrome
- ☐ Congenital Heart Defect
- ☐ Heart Murmur
- ☐ Rheumatic Heart Disease
- ☐ Mitral Valve Prolapse
- ☐ Elevated/High Blood Pressure
- ☐ Heart Palpitations or Irregular Beat
- ☐ Chest Pain, Pressure, Discomfort
- ☐ Elevated Cholesterol
- ☐ Syncope/Fainting/Dizziness
- ☐ Syncope or Near Syncope with exercise or exertion
- ☐ Chest Pain/discomfort with exercise

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

Metabolic
- ☐ Diabetes Mellitus
- ☐ Thyroid Disorder

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

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

Mental/Emotional Health
- ☐ 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: ________

For assistance from Counseling Center call 716-888-2620

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

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

Disability
- ☐ Vision
- ☐ Hearing
- ☐ Physical
- ☐ Mobility with assistance
- ☐ Mobility without assistance
- ☐ Emotional/Psychological
- ☐ Chronic Medical
- ☐ Learning
- ☐ ADD/ADHD
- ☐ Speech
- ☐ Other: ________

To set up accommodations, call Disability Support Services at 716- 888-3748

Do you use tobacco?
☐ No | ☐ Yes – packs/day________

Do you drink alcohol?
☐ No | ☐ Yes – amount/week _____

Current medicines including vitamins and supplements: **(in English)**

____

____

Explain all checked answers here: ________

Family History

Family History	Age	State of Health	Occupation	Age of Death	Cause of Death
Father					
Mother					
Brothers					
Sisters					

Allergies Please check below
- ☐ Allergic to medications
- ☐ Allergic to X-ray dyes
- ☐ Allergic to food/insects/ environmental

Please list all: **(in English)**

____

____

____

Have any of your relatives ever had any of the following?

	Yes	Relationship		Yes	Relationship
Alcoholism			Cancer		
Tuberculosis			Mental Illness		
Arthritis			Premature death from heart disease or other Non-traumatic causes		
Asthma, Hay Fever					
Diabetes			Marfan Syndrome		
Epilepsy, Convulsions			Kidney Disease		
Heart Disease			Disability due to heart disease		
High Blood Pressure			Other (specify)		

Surgeries (in English)
- ☐ Appendectomy
- ☐ Ear tubes
- ☐ Tonsils/ Adenoids
- ☐ Mole removal
- ☐ Hernia repair
- ☐ Wisdom Teeth Extraction
- ☐ Other: (specify below)

____

____

____

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 (or parent/guardian if student under 18) | Date – Month / Day / Year

Immunizations | Healthcare provider to complete in English, sign and date.

Name of Student	Date of Birth: Month	Day	Year

❖ These are a requirement of New York State and must be completed to attend Canisius College.

Vaccine	Requirement				
❖ MMR (Measles, Mumps, Rubella)	If born on or after 1/1/57 two doses required. **Dose #1** must be given on or after first birthday. **Dose #2** must be given after 15 months of age and at least 28 days after 1st dose.	Dose #1 ___/___/___ M D Y	Dose #2 ___/___/___ M D Y		
❖ Measles	If born on or after 1/1/57 two doses of live measles vaccine are required **or** disease date **or** positive serology.	Dose #1 ___/___/___ M D Y	Dose #2 ___/___/___ M D Y	Disease date ___/___/___ M D Y	Serology date ___/___/___ M D Y ☐ Immune
❖ Mumps	If born on or after 1/1/57 one dose of live mumps vaccine is required **or** disease date **or** positive serology.	Dose #1 ___/___/___ M D Y	Disease date ___/___/___ M D Y	Serology date ___/___/___ M D Y ☐ Immune	
❖ Rubella	If born on or after 1/1/57 one dose of live rubella vaccine is required **or** positive serology.	Dose #1 ___/___/___ M D Y	Serology date ___/___/___ M D Y ☐ Immune		
Meningococcal Vaccine	One dose of either: ☐ Menomune™ or ☐ Menactra™	___/___/___ M D Y			
Varicella Vaccine	Two doses, disease date or serology results.	Dose #1 ___/___/___ M D Y	Dose #2 ___/___/___ M D Y	Disease date ___/___/___ M D Y	Serology date ___/___/___ M D Y ☐ Immune
Tetanus, Diptheria Pertussis	Dose within 10 years. Please specify: ☐ Td ☐ Tdap	___/___/___ M D Y			
Polio Vaccine	Date series completed.	___/___/___ M D Y			
Hepatitis B Vaccine	Series of 3 doses.	Dose #1 ___/___/___ M D Y	Dose #2 ___/___/___ M D Y	Dose #3 ___/___/___ M D Y	
Hepatitis A Vaccine	Series of 2 doses.	Dose #1 ___/___/___ M D Y	Dose #2 ___/___/___ M D Y		
HPV Females only	Series of 3 doses.	Dose #1 ___/___/___ M D Y	Dose #2 ___/___/___ M D Y	Dose #3 ___/___/___ M D Y	

TB Screening (Required for International Students from high risk countries **)

1. Does the student have signs or symptoms of active TB disease | ☐ Yes | ☐ No If NO, proceed to question two.
   If YES, proceed with additional evaluation to exclude active TB disease including tuberculin skin testing, chest X-ray and sputum evaluation as indicated.
2. Is the student a member of a high risk group,* or an international student from a country not listed below.**
   | ☐ Yes | ☐ No **IF NO, STOP.** No further evaluation is needed at this time. If YES, place tuberculin skin test (Mantoux only: Inject 0.1 ml of purified protein derivative [PPD] tuberculin containing five tuberculin units [TU] intradermally into the volar [inner] surface of the forearm.)
   A history of BCG vaccination does not preclude testing of a member of a high-risk group. History of BCG vaccine | ☐ Yes | ☐ No
3. Tuberculin Skin Test: (Mantoux) **Must be within six months.**
   Date given: ___/___/___ (M D Y) Date read: ___/___/___ (M D Y)
   Result:_______ (record actual mm of induration, transverse diameter: if no induration, write "0".)
   Interpretation (based on mm of induration as well as risk factors): | ☐ Positive | ☐ Negative
4. Chest X-ray (required if tuberculin skin test is positive): | Date of chest x-ray: ___/___/___ (M D Y)
   Result: | ☐ Normal | ☐ Abnormal | Explain:_______________
5. Treatment Plan if indicated: _______________

* High risk students include those with HIV infection, who inject drugs, who have resided in, volunteered in, or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS or homeless shelters: and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and 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 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	Date – Month / Day / Year

03/2008-250 | 480.0708

Physical Examination | **Must be completed in English, signed and dated by Healthcare Provider examining this student.**

Entering Fall 2008 PE must be given after March 1, 2008.
Entering Spring 2009 PE must be given after August 1, 2008.

| ______________ Name | Month ____ Day ____ Year ____ Date of Birth | ☐ Male ☐ Female Gender |

Height: ______________ Weight: ______________ Blood Pressure: ______________ Pulse: ______________

Lab: Sickle Cell Screen: | ☐ Positive | ☐ Negative

Clinical Evaluation	**Normal**	**Abnormal**	**Comments**
1. Skin			
2. Head, Ears, Eyes, Nose, Throat, Hearing, Visual Acuity			
3. Mouth, Teeth, Gums			
4. Neck and Thyroid			
5. Lungs/Chest			
6. Breasts			
7. Heart (supine and standing)			
8. Abdomen			
9. Genitalia			
10. Back/Spine			
11. Extremities/Musculoskeletal/Femoral Pulses			
12. Neurologic			
13. Emotional/Psychological			
14. Other Findings			

15. Physical stigmata of Marfan Syndrome | ☐ Not present | ☐ Present Describe: ______________

Is there loss of or seriously impared function of any paired organ? | ☐ No | ☐ Yes If yes, please explain: ______________

Is this student cleared for full physical activity, including participation in intramural, club and 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: ______________

Recommendations: ______________

I have reviewed the medical history and examined the student noted above. The information is accurate and complete to the best of my knowledge.

| ______________ Signature of Health Care Provider | ______________ Date – Month / Day / Year

| ______________ Print Name of Healthcare Provider | ______________ Address | ______________ Phone | ______________ Fax

Do not write below this line

Review done by: initials ______________ date ______________

☐ PE and Immunization Complete

☐ Missing/Incomplete for:

☐ Immunizations ______________ ☐ TST ______________

☐ PE ______________ ☐ Health Insurance ______________

Missing Information Notification

| ☐ Letter | ☐ E-mail | ☐ Phone | ☐ In-Person

initials ______________ date ______________