



2010-2011 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
www.canisius.edu/student_health

All students must submit this completed form to Student Health. NO OTHER FORM WILL BE ACCEPTED.

Incomplete or overdue forms will stop registration.

For fall 2010 attendance: Physicals must be done after March 1, 2010 and submitted by July 31, 2010.

For spring 2011 attendance: Physicals must be done after August 1, 2010 and submitted by January 1, 2011.

_____			_____			_____		
Last Name			First Name			Middle Initial		
_____	_____	_____	_____	<input type="checkbox"/> Male	<input type="checkbox"/> Female	_____		
Date of Birth		Student ID	Gender		E-mail address			
_____			_____			_____		
Permanent Address			Country code, city code, Phone			Country code Cell Phone		
_____			_____			_____		
City or Town			Country			Postal Code		Citizenship

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

_____		_____		_____		_____	
Emergency Contact – name and relationship		Country code, city code Phone		Cell Phone		Work Phone	
_____		_____		_____		_____	
Emergency Contact Address		City		Country		Postal Code	
_____		_____		_____		_____	
E-Mail Address		Postal Code		Country		City	

Personal Physician

_____		_____		_____		_____	
Primary Physician		Address		Phone		Fax	

PLEASE DO NOT PURCHASE AN ALTERNATE HEALTH INSURANCE PLAN
All international students must purchase a specific 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 (Menomune™ or Menactra™) within the past 10 years: _____
- 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 M D Y			

Authorization for Treatment (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.

_____				_____ / _____ / _____			
Signature of Student or Parent/Guardian for minor (Required)				Date M D Y			

Medical History | Student to complete and sign or Parent/Guardian for minor students

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

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

Metabolic

- Diabetes Mellitus
- Thyroid Disorder

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

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: _____

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: _____

Do you use tobacco?

- No | Yes - packs/day _____

Do you drink alcohol?

- No | Yes - amount/week _____

Current medicines including vitamins and supplements:

Explain all checked answers here: _____

Family History	Age	State of Health	If deceased, Age of Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Allergies: None

- Allergic to medications
- Allergic to X-ray dyes
- Allergic to food/insects/ environmental

Please list all:

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

	Yes	Relationship	Yes	Relationship
Alcoholism				Cancer
Asthma, Hay Fever				Mental Illness
Diabetes				Elevated Blood Pressure
Seizure Disorder				Kidney Disease
Disability due to heart disease before age 50				Premature Cardiac Death sudden or otherwise
Other heart related diagnosis, cardiomyopathies, long QT syndrome, Marfan syndrome, arrhythmias				Other (specify below):

Surgeries: None

- 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)

Immunizations | Healthcare provider must complete in English and sign at the bottom of this page.

No other immunization documents will be accepted. Do not send immunization attachments.

Name of Student _____ | Month _____ | Day _____ | Year _____
 Date of Birth _____

MMR (Measles, Mumps, Rubella)	If born on or after 1/1/57, two doses of live MMR vaccine 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 1 st dose.	Dose #1 __ / __ / __ M D Y	Dose #2 __ / __ / __ M D Y		
Measles	If born on or after 1/1/57, two live 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 1 st dose.	Dose #1 __ / __ / __ M D Y	Dose #2 __ / __ / __ M D Y	Disease date __ / __ / __ M D Y	Serology date __ / __ / __ M D Y <input type="checkbox"/> Immune
Mumps	If born on or after 1/1/57, one live dose required. Dose #1 administered on or after 1 st birthday.	Dose #1 __ / __ / __ M D Y		Disease date __ / __ / __ M D Y	Serology date __ / __ / __ M D Y <input type="checkbox"/> Immune
Rubella	If born on or after 1/1/57, one live dose required. Dose #1 administered on or after 1 st birthday.	Dose #1 __ / __ / __ M D Y			Serology date __ / __ / __ M D Y <input type="checkbox"/> Immune
Meningococcal Vaccine	One dose of either: <input type="checkbox"/> Menomune™ or <input type="checkbox"/> Menactra™	Dose #1 __ / __ / __ 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 <input type="checkbox"/> Immune
Tetanus, Diphtheria Pertussis	Dose within 10 years. Please specify: <input type="checkbox"/> Td <input type="checkbox"/> Tdap	Dose #1 __ / __ / __ M D Y			
Polio Vaccine	Date primary series completed.	Dose #1 __ / __ / __ 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 Risk Assessment - All international students must be screened. If in a risk group, a Tuberculin skin test is required.

- Does the student have signs or symptoms of active TB disease | Yes (go to Tuberculin Skin Test) | No (go to question #2)
- Is the student a member of a high risk group,* or an international student from a country not listed below.**
 | Yes (go to Tuberculin Skin Test) | No (STOP. No further screening needed)

Tuberculin Skin Test Required for this student:

Has this student ever received a BCG vaccination? | Yes __ / __ / __ | No

Tuberculin Skin Test: (Mantoux only) (MUST BE GIVEN WITHIN 6 MONTHS OF ATTENDING CANISIUS COLLEGE.)

Date placed: __ / __ / __ Date read: __ / __ / __
 M D Y 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 (Chest X-ray required) | Negative

Chest X-ray date: __ / __ / __ Result: Normal X-ray | Abnormal findings (explain: _____)

Treatment Plan (include plan for TB prophylaxis treatment): _____

* 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 jejunioileal 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 travel 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 | To be completed, signed and dated by Healthcare Provider in English.

*** No other form will be accepted**

Entering Fall 2010 PE must be given after March 1, 2010. Entering Spring 2011 PE must be given after August 1, 2010.

| _____ | Month | Day | Year | Male | Female
 Name Date of Birth Gender

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

For Division 1 Athletes Only- Sickle Cell Screen: | Positive | Negative

Clinical Evaluation	Normal	Abnormal	Comments
1. Skin			
2. Head, Ears, Eyes, Nose, 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	<input type="checkbox"/> Not Present <input type="checkbox"/> Present Please explain: _____		
16. Is there loss of or seriously impaired function of any paired organ?	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please explain: _____		
17. 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?	<input type="checkbox"/> Yes/ Unlimited activity and fit for college <input type="checkbox"/> No/Limited activity Reason: _____		
Recommendations:	_____		

I attest I have reviewed the medical history and immunization records, conducted a TB risk assessment and examined this student. The information provided on this form is complete, full and accurate to the best of my knowledge. (Please date your signature)

| _____ | _____ / _____ / _____
 Signature of Health Care Provider Date M D Y

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

Do not write below this line

Reviewed by: Initials _____ Date _____

Incomplete for:

- NYS Imm. _____ PE _____ Med Hx Insurance Card
- TB Screen/TST _____ Parental Authority Other

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

PE and Immunization Complete: Initials _____ Date _____