INTERNATIONAL STUDENTS

PHYSICAL & IMMUNIZATION FORM

All international students (graduate and undergraduate) must complete and submit this form to Student Health.

Minor students must have a parent or guardian complete the form.

If attending in fall form is due July 31
If attending in spring form is due January 1

Incomplete or overdue forms can result in registration withdrawal and prevent sports participation.

Physical examinations must be done within 12 months of attendance. For intercollegiate Division 1 athletes, physical examinations must be done within 6 months for sports participation.

*Please note, date format Month/Day/Year (MM/DD/YY).

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>MIDDLE INITIAL</th>
<th>COLLEGE ID / MEDICAT ID</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DATE OF BIRTH (MM/DD/YYYY) GENDER EMAIL ADDRESS

PERMANENT ADDRESS CITY STATE ZIP CODE

HOME PHONE 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 HOME PHONE CELL PHONE WORK PHONE

EMERGENCY CONTACT - ADDRESS CITY COUNTRY POSTAL CODE EMAIL ADDRESS

PERSONAL PHYSICIAN

PERSONAL PRIMARY PHYSICIAN ADDRESS PHONE FAX

CONSENT TO TREAT, ATTESTATION, AUTHORIZATIONS

Without signature Student Health can not treat this student. Parent or 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. I agree to the provision of care either by in person physical examination or remotely via telemedicine. This care 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. I authorize Student Health to communicate with me using my secure health portal, myCanisiusHealth. This communication may include but is not limited to lab results, clinical notes and additional medical recommendations for my ongoing care and treatment each semester I am a registered student at the college. Access to myCanisiusHealth is limited to the current semester enrolled. I also attest that I understand the limitations and possible risk of telemedicine visits.

SIGNATURE OF STUDENT (REQUIRED) DATE (MM/DD/YY)

SIGNATURE OF PARENT/GUARDIAN FOR MINOR (REQUIRED) DATE (MM/DD/YY)

DO NOT WRITE BELOW THIS LINE

REVIEWED BY: Initials Date ________________________
**IMMUNIZATIONS**

NEW YORK STATE LAW - For health care provider to complete, sign and stamp. Immunization records attached to this form must be signed or stamped by health care provider.

Please record all dates as Month/Day/Year

*New York State required vaccinations or response.

**Canisius College Requirement. All others are recommendations.

<table>
<thead>
<tr>
<th>IMMUNIZATIONS</th>
<th>Dose #1</th>
<th>Dose #2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MMR</strong> (Measles, Mumps, Rubella)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If born after 1956, two doses of MMR vaccine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>required. Dose #1 administered on or after the 1st</td>
<td></td>
<td></td>
</tr>
<tr>
<td>birthday. Dose #2 administered at least 28 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>after the first dose.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MMR Serology/Titer</th>
<th>Measles Titer Date</th>
<th>Mumps Titer Date</th>
<th>Rubella Titer Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory confirmation of immunity,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>if unable to verify MMR vaccinations (Laboratory</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>report must be submitted with this form).</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| *MENINGOCOCCAL QUADRIVALENT*                      |                  |                  |
| One dose ACYW within past 5 years                 |                  |                  |

| *MENINGOCOCCAL SEROGROUP B*                       |                  |                  |
| Completed series of two or three doses within     |                  |                  |
| past 5 years                                      |                  |                  |

| **COVID 19** (SARS CoV2)                          |                  |                  |
| Completion of primary series and boosted when     |                  |                  |
| eligible.                                         |                  |                  |

| VARICELLA VACCINE                                 |                  |                  |
| Two doses, disease date or serology.              |                  |                  |

| TETANUS, DIPHTHERIA PERTUSSIS                     |                  |                  |
| One booster within last 10 years. A single       |                  |                  |
| dose of Tdap recommended for all students.       |                  |                  |

| POLIO VACCINE                                     |                  |                  |
| Date primary series completed.                    |                  |                  |

| HEPATITIS B VACCINE                               |                  |                  |
| Series of 3 doses.                                |                  |                  |

| HEPATITIS A VACCINE                               |                  |                  |
| Series of 2 doses.                                |                  |                  |

| HPV                                               |                  |                  |
| Two or Three doses based on 2016 ACIP guidelines  |                  |                  |

<table>
<thead>
<tr>
<th>HEALTH CARE PROVIDER SIGNATURE</th>
<th>HEALTH CARE PROVIDER PRINTED NAME / STAMP</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS</td>
<td>PHONE</td>
</tr>
</tbody>
</table>

**MENINGITIS RESPONSE: IMPORTANT – THIS RESPONSE IS REQUIRED BY NEW YORK STATE LAW FOR ALL STUDENTS IF NOT VACCINATED WITHIN THE PAST 5 YEARS.**

I have 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 OR PARENT/GUARDIAN OF MINOR STUDENT | DATE (MM/DD/YY)
**MEDICAL HISTORY**

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

### INFECTIOUS DISEASE
- [ ] Chicken Pox
- [ ] Infectious Mononucleosis
- [ ] Rheumatic Fever
- [ ] Scarlet Fever
- [ ] Tuberculosis
- [ ] Malaria
- [ ] COVID-19 Disease date: ___________
- [ ] History of Positive TB Test

### EYES, EARS, NOSE, THROAT
- [ ] Wear Glasses/Contacts
- [ ] 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
- [ ] 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 Bowl
- [ ] Crohn’s Disease
- [ ] Ulcerative Colitis
- [ ] Hemorrhoids

### 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: ______________________

**MEDICATIONS**

- [ ] None
- [ ] Allergic to medications
- [ ] Allergic to X-ray dyes
- [ ] Allergic to food/insects/environmental

**SURGERIES**

- [ ] None
- [ ] Appendectomy
- [ ] Hernia repair
- [ ] Male Removal
- [ ] Ear Tubes
- [ ] Wisdom Teeth Extraction
- [ ] Tonsils/Adenoids
- [ ] Other: (specify below)

**ALLERGIES**

- [ ] None
- [ ] Allergic to medications
- [ ] Allergic to X-ray dyes
- [ ] Allergic to food/insects/environmental

**FAMILY HISTORY**

<table>
<thead>
<tr>
<th>Relative</th>
<th>Age</th>
<th>State of Health</th>
<th>If Deceased</th>
<th>Age of Death</th>
<th>Cause of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Siblings</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcoholism</td>
<td></td>
<td>Cancer</td>
</tr>
<tr>
<td>Asthma, Hay Fever</td>
<td></td>
<td>Mental Illness</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td>Kidney Disease</td>
</tr>
<tr>
<td>Sickle Cell Trait/Disease</td>
<td></td>
<td>Seizure Disorder</td>
</tr>
<tr>
<td>Disability due to heart disease before age 50</td>
<td></td>
<td>Marfan syndrome</td>
</tr>
<tr>
<td>Elevated Blood Pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other heart related diagnosis, cardiomyopathies, long QT syndrome, arrhythmias</td>
<td></td>
<td>Other (list):</td>
</tr>
</tbody>
</table>

**Additional information you wish to share about your health:**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
TO BE COMPLETED, SIGNED AND DATED BY HEALTHCARE PROVIDER.

CLINICAL EVALUATION

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. ACTIVITY CLEARANCE
   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 - Full activity and fit for college  □ NO - Limited activity  Reason:

18. Additional Comments/Recommendations:

I have reviewed the medical history and immunizations, conducted the 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.

HEALTH CARE PROVIDER SIGNATURE
HEALTH CARE PROVIDER PRINTED NAME / STAMP
DATE OF EXAM (MM/DD/YY)