UNDERGRADUATE PHYSICAL & IMMUNIZATION FORM

All undergraduates 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 will delay or cancel registration 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).

Mail form to: **STUDENT HEALTH CENTER**
2001 Main Street, Buffalo, NY 14208
P: 716.888.2610
Fax form to: 716.888.3217
canisius.edu/student_health

Upload this form to your new student portal at Student Health

LAST NAME | FIRST NAME | MIDDLE INITIAL | COLLEGE ID / MEDICAT ID

☐ MALE ☐ FEMALE

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

HEALTH INSURANCE: PLEASE CARRY YOUR HEALTH INSURANCE CARD WHILE ON CAMPUS.

CONSENT TO TREAT, ATTESTATION, AUTHORIZATION FOR MYCANISIUSHEALTH PORTAL

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. 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. 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 authorize Student Health to communicate with me via text messaging to my cell phone. This communication may include, but is not limited to, appointment reminders, appointment verifications and notifications needed for provision of care and treatment.

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

NAME OF STUDENT | DATE OF BIRTH (MM/DD/YYYY) | COLLEGE ID #

MMR (Measles, Mumps, Rubella)	If born after 1956, two doses of MMR vaccine required. **Dose #1** administered on or after the 1st birthday. **Dose #2** administered at least 28 days after the first dose.	Dose #1 ___ /___ /___ MM DD YY	Dose #2 ___ /___ /___ MM DD YY		
MMR Serology/Titer	Laboratory confirmation of immunity. **(Laboratory report must be submitted with this form)**.	Measles Titer Date ___ /___ /___ MM DD YY ☐ Immune ☐ Non Immune	Mumps Titer Date ___ /___ /___ MM DD YY ☐ Immune ☐ Non Immune	Rubella Titer Date ___ /___ /___ MM DD YY ☐ Immune ☐ Non Immune	
***MENINGOCOCCAL QUADRIVALENT**	One dose ACYW within past 5 years	Dose #1 ___ /___ /___ MM DD YY	Dose #2 ___ /___ /___ MM DD YY		
***MENINGOCOCCAL SEROGROUP B**	Completed series of two or three doses within past 5 years	MenB-RC (Bexsero) Dose #1 ___ /___ /___ MM DD YY	MenB-RC (Bexsero) Dose #2 ___ /___ /___ MM DD YY	MenB-FHbp (Trumenba) Dose #1 ___ /___ /___ MM DD YY	MenB-FHbp (Trumenba) Dose #2 ___ /___ /___ MM DD YY
				MenB-FHbp (Trumenba) Dose #3 ___ /___ /___ 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.	☐ 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	Two or Three doses based on 2016 ACIP guidelines	Dose #1 ___ /___ /___ MM DD YY	Dose #2 ___ /___ /___ MM DD YY	Dose #3 ___ /___ /___ MM DD YY	

HEALTH CARE PROVIDER SIGNATURE | **HEALTH CARE PROVIDER PRINTED NAME / STAMP**

ADDRESS | **PHONE**

*** 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

NAME OF STUDENT _____ DATE OF BIRTH (MM/DD/YYYY) _____ COLLEGE ID # _____

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

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 Infection

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	If Deceased, State of Health	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					

PHYSICAL EXAMINATION

TO BE COMPLETED, SIGNED AND DATED BY HEALTHCARE PROVIDER.

☐ MALE ☐ FEMALE

NAME | DATE OF BIRTH (MM/DD/YYYY) | GENDER

HEIGHT | WEIGHT | BLOOD PRESSURE | PULSE

SICKLE CELL SCREEN REQUIRED FOR ALL D1 ATHLETES Sickle Cell Screen Date: MONTH _____ DAY _____ YEAR _____

☐ Positive ☐ Negative

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 from a high risk country.

☐ YES (go to TB Test) ☐ NO (**STOP** No further screening needed)

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)

TB SKIN TEST OR TB BLOOD TEST

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): _____

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. **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**

ADDRESS | **PHONE**

1/2019- | 165.1819