

# UNDERGRADUATE PHYSICAL & IMMUNIZATION FORM



All undergraduates should 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 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](http://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	
		<input type="checkbox"/> MALE <input type="checkbox"/> 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
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**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.

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 - Health care provider complete and sign the immunization section. Immunization records attached to this form must be signed or stamped.**

**Please record all dates as Month/Day/Year**

NAME OF STUDENT

DATE OF BIRTH (MM/DD/YYYY)

COLLEGE ID #

<b>MMR</b> (Measles, Mumps, Rubella)	If born after 1956, two doses of MMR vaccine required. <b>Dose #1</b> administered on or after the 1 <sup>st</sup> birthday. <b>Dose #2</b> administered at least 28 days after the first dose.	Dose #1 MM / DD / YY	Dose #2 MM / DD / YY			
<b>MMR Serology/Titer</b>	Laboratory confirmation of immunity. <b>(Laboratory report must be submitted with this form).</b>	Measles Titer Date MM / DD / YY <input type="checkbox"/> Immune <input type="checkbox"/> Non Immune	Mumps Titer Date MM / DD / YY <input type="checkbox"/> Immune <input type="checkbox"/> Non Immune	Rubella Titer Date MM / DD / YY <input type="checkbox"/> Immune <input type="checkbox"/> Non Immune		
<b>*MENINGOCOCCAL QUADRIVALENT</b>	One dose ACYW within past 5 years	Dose #1 MM / DD / YY	Dose #2 MM / DD / YY			
<b>*MENINGOCOCCAL SEROGROUP B</b>	Completed series of two or three doses within past 5 years	MenB-RC (Bexsero)		MenB-FHbp (Trumenba)		
		Dose #1 MM / DD / YY	Dose #2 MM / DD / YY	Dose #1 MM / DD / YY	Dose #2 MM / DD / YY	Dose #3 MM / DD / YY
<b>VARICELLA VACCINE</b>	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 <input type="checkbox"/> Immune	
<b>TETANUS, DIPHTHERIA PERTUSSIS</b>	One booster within last 10 years. A single dose of Tdap recommended for all students.	<input type="checkbox"/> Tdap MM / DD / YY	<input type="checkbox"/> Td MM / DD / YY			
<b>POLIO VACCINE</b>	Date primary series completed.	MM / DD / YY				
<b>HEPATITIS B VACCINE</b>	Series of 3 doses.	Dose #1 MM / DD / YY	Dose #2 MM / DD / YY	Dose #3 MM / DD / YY		
<b>HEPATITIS A VACCINE</b>	Series of 2 doses.	Dose #1 MM / DD / YY	Dose #2 MM / DD / YY			
<b>HPV</b>	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

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	Have any of your relatives ever had any of the following?				
					Yes	Relationship		Yes	Relationship
Father							Alcoholism		Cancer
Mother							Asthma, Hay Fever		Mental Illness
Siblings							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.

NAME \_\_\_\_\_ DATE OF BIRTH (MM/DD/YYYY) \_\_\_\_\_ GENDER  MALE  FEMALE

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ BLOOD PRESSURE \_\_\_\_\_ PULSE \_\_\_\_\_

**DIVISION 1 ATHLETES SICKLE CELL SCREEN RECOMMENDED** 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)

<p><b>TUBERCULIN SKIN TEST:</b> (Mantoux only)                  Date placed: ____/____/____ Date read: ____/____/____                  Result: ____mm of induration                  Interpretation based on mm of induration and risk factors:  <input type="checkbox"/> Negative <input type="checkbox"/> Positive (Chest X-ray required)</p>	<p><b>TB SKIN TEST OR TB BLOOD TEST</b></p>	<p><b>IGRA:</b> (Specify method) <input type="checkbox"/> QFT-G <input type="checkbox"/> QFT-GIT <input type="checkbox"/> T-SPOT                  Date Tested: ____/____/____                  Result: <input type="checkbox"/> Negative  <input type="checkbox"/> Indeterminate/Borderline (repeat in 6-8 weeks)  <input type="checkbox"/> Positive (Chest X-Ray required)</p>
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Chest X-Ray Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ 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		
<b>17. ACTIVITY CLEARANCE</b> 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? <input type="checkbox"/> <b>YES</b> - Full activity and fit for college <input type="checkbox"/> <b>NO</b> - 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 \_\_\_\_\_ DATE OF EXAM (MM/DD/YY) \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_