INTERNATIONAL STUDENTS
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).

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 ______________________
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

<table>
<thead>
<tr>
<th>IMMUNIZATIONS</th>
<th>Dose #1</th>
<th>Dose #2</th>
<th>Dose #3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NAME OF STUDENT</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DATE OF BIRTH (MM/DD/YYYY)</strong></td>
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</tr>
<tr>
<td><strong>COLLEGE ID #</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>MMR</strong> (Measles, Mumps, Rubella)</td>
<td></td>
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</tr>
<tr>
<td>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.</td>
<td>MM/ DD/ YY</td>
<td>MM/ DD/ YY</td>
<td>MM/ DD/ YY</td>
</tr>
<tr>
<td><strong>MMR Serology/Titer</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory confirmation of immunity. (Laboratory report must be submitted with this form).</td>
<td>Measles Titer Date</td>
<td>Mumps Titer Date</td>
<td>Rubella Titer Date</td>
</tr>
<tr>
<td></td>
<td>__ / ___ / ___</td>
<td>__ / ___ / ___</td>
<td>__ / ___ / ___</td>
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<tr>
<td></td>
<td>Immune</td>
<td>Immune</td>
<td>Immune</td>
</tr>
<tr>
<td></td>
<td>Non Immune</td>
<td>Non Immune</td>
<td>Non Immune</td>
</tr>
<tr>
<td><strong>MENINGOCOCCAL QUADRIVALENT</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One dose ACYW within past 5 years</td>
<td>Dose #1</td>
<td>Dose #2</td>
<td>MenB-RC (Bexsero)</td>
</tr>
<tr>
<td>Dose #1</td>
<td>__ / ___ / ___</td>
<td>__ / ___ / ___</td>
<td>MM/ DD/ YY</td>
</tr>
<tr>
<td>Dose #2</td>
<td>__ / ___ / ___</td>
<td>__ / ___ / ___</td>
<td>MM/ DD/ YY</td>
</tr>
<tr>
<td><strong>MENINGOCOCCAL SEROGROUP B</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completed series of two or three doses within past 5 years</td>
<td>MenB-RC (Bexsero)</td>
<td>MenB-FHbp (Trumenba)</td>
<td></td>
</tr>
<tr>
<td>Dose #1</td>
<td>__ / ___ / ___</td>
<td>__ / ___ / ___</td>
<td>MM/ DD/ YY</td>
</tr>
<tr>
<td>Dose #2</td>
<td>__ / ___ / ___</td>
<td>__ / ___ / ___</td>
<td>MM/ DD/ YY</td>
</tr>
<tr>
<td><strong>VARICELLA VACCINE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two doses, disease date or serology.</td>
<td>Dose #1</td>
<td>Dose #2</td>
<td>Disease Date</td>
</tr>
<tr>
<td>Dose #1</td>
<td>__ / ___ / ___</td>
<td>__ / ___ / ___</td>
<td>MM/ DD/ YY</td>
</tr>
<tr>
<td>Dose #2</td>
<td>__ / ___ / ___</td>
<td>__ / ___ / ___</td>
<td>MM/ DD/ YY</td>
</tr>
<tr>
<td><strong>TETANUS, DIPHTHERIA PERTUSSIS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One booster within last 10 years. A single dose of Tdap recommended for all students.</td>
<td>Tdap</td>
<td>Td</td>
<td>Serology Date</td>
</tr>
<tr>
<td>Tdap</td>
<td>__ / ___ / ___</td>
<td>__ / ___ / ___</td>
<td>MM/ DD/ YY</td>
</tr>
<tr>
<td>Td</td>
<td>__ / ___ / ___</td>
<td>__ / ___ / ___</td>
<td>MM/ DD/ YY</td>
</tr>
<tr>
<td><strong>POLIO VACCINE</strong></td>
<td></td>
<td></td>
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<tr>
<td>Date primary series completed.</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>__ / ___ / ___</td>
<td>__ / ___ / ___</td>
<td>MM/ DD/ YY</td>
</tr>
<tr>
<td><strong>HEPATITIS B VACCINE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Series of 3 doses.</td>
<td>Dose #1</td>
<td>Dose #2</td>
<td>Dose #3</td>
</tr>
<tr>
<td>Dose #1</td>
<td>__ / ___ / ___</td>
<td>__ / ___ / ___</td>
<td>__ / ___ / ___</td>
</tr>
<tr>
<td>Dose #2</td>
<td>__ / ___ / ___</td>
<td>__ / ___ / ___</td>
<td>__ / ___ / ___</td>
</tr>
<tr>
<td><strong>HEPATITIS A VACCINE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Series of 2 doses.</td>
<td>Dose #1</td>
<td>Dose #2</td>
<td></td>
</tr>
<tr>
<td>Dose #1</td>
<td>__ / ___ / ___</td>
<td>__ / ___ / ___</td>
<td>__ / ___ / ___</td>
</tr>
<tr>
<td>Dose #2</td>
<td>__ / ___ / ___</td>
<td>__ / ___ / ___</td>
<td>__ / ___ / ___</td>
</tr>
<tr>
<td><strong>HPV</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two or Three doses based on 2016 ACIP guidelines</td>
<td>Dose #1</td>
<td>Dose #2</td>
<td>Dose #3</td>
</tr>
<tr>
<td>Dose #1</td>
<td>__ / ___ / ___</td>
<td>__ / ___ / ___</td>
<td>__ / ___ / ___</td>
</tr>
<tr>
<td>Dose #2</td>
<td>__ / ___ / ___</td>
<td>__ / ___ / ___</td>
<td>__ / ___ / ___</td>
</tr>
</tbody>
</table>

**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)**
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: _______________________________

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
  ____________________________________________________________________________

**FAMILY HISTORY**

<table>
<thead>
<tr>
<th>Family Member</th>
<th>Age</th>
<th>If Deceased, State of Health</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>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Siblings</td>
<td></td>
<td></td>
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</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</td>
<td></td>
<td>Marfan Syndrome</td>
</tr>
<tr>
<td>Elevated Blood Pressure</td>
<td></td>
<td>Other (list):</td>
</tr>
<tr>
<td>Other heart related diagnosis,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>cardiomyopathies, long QT syndrome, arrhythmias</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### PHYSICAL EXAMINATION

**SICKLE CELL SCREEN REQUIRED FOR ALL D1 ATHLETES**

Sickle Cell Screen Date: MONTH ____ DAY ____ YEAR ____

- □ Positive
- □ Negative

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

<table>
<thead>
<tr>
<th>NAME</th>
<th>DATE OF BIRTH (MM/DD/YYYY)</th>
<th>GENDER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>MALE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FEMALE</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HEIGHT</th>
<th>WEIGHT</th>
<th>BLOOD PRESSURE</th>
<th>PULSE</th>
</tr>
</thead>
<tbody>
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<td></td>
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</table>

<table>
<thead>
<tr>
<th><strong>CLINICAL EVALUATION</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NORMAL</strong></td>
</tr>
<tr>
<td><strong>RECORD ABNORMAL FINDINGS</strong></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>HEALTH CARE PROVIDER SIGNATURE</th>
<th>HEALTH CARE PROVIDER PRINTED NAME</th>
<th>DATE OF EXAM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

ADDRESS | PHONE