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 cancellation 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

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

<table>
<thead>
<tr>
<th>Vaccination</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR (Measles, Mumps, Rubella)</td>
<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>
</tr>
<tr>
<td>MMR Serology/Titer</td>
<td>Laboratory confirmation of immunity. (Laboratory report must be submitted with this form).</td>
</tr>
<tr>
<td>Meningococcal Quadrivalent</td>
<td>One dose ACYW within past 5 years</td>
</tr>
<tr>
<td>Meningococcal Serogroup B</td>
<td>Completed series of two or three doses within past 5 years</td>
</tr>
<tr>
<td>Varicella Vaccine</td>
<td>Two doses, disease date or serology.</td>
</tr>
<tr>
<td>Tetanus, Diphtheria Pertussis</td>
<td>One booster within last 10 years. A single dose of Tdap recommended for all students.</td>
</tr>
<tr>
<td>Polio Vaccine</td>
<td>Date primary series completed.</td>
</tr>
<tr>
<td>Hepatitis B Vaccine</td>
<td>Series of 3 doses.</td>
</tr>
<tr>
<td>Hepatitis A Vaccine</td>
<td>Series of 2 doses.</td>
</tr>
<tr>
<td>HPV</td>
<td>Two or Three doses based on 2016 ACIP guidelines</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

**MUSCULOSKELETAL**
- Rheumatoid Arthritis
- Osteoarthritis
- Spondylitis
- Spondylosis
- Scoliosis
- Spina Bifida
- Hip Dysplasia
- 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**
- Other Important Medical History: 

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

**MEDICATIONS**
- None

**SURGERIES**
- None

**FAMILY HISTORY**

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

**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>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DIVISION 1 ATHLETES SICKLE CELL SCREEN RECOMMENDED**

<table>
<thead>
<tr>
<th>Sickle Cell Screen Date: MONTH _____ DAY _____ YEAR _____</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Positive ☐ Negative</td>
</tr>
</tbody>
</table>

**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)**

<table>
<thead>
<tr>
<th>Date placed: _____ / _____ / _____</th>
<th>Date read: _____ / _____ / _____</th>
</tr>
</thead>
<tbody>
<tr>
<td>mm of induration</td>
<td>Interpretation based on mm of induration and risk factors:</td>
</tr>
<tr>
<td>☐ Negative ☐ Positive (Chest X-ray required)</td>
<td></td>
</tr>
</tbody>
</table>

**TB SKIN TEST OR TB BLOOD TEST**

<table>
<thead>
<tr>
<th>Date Tested: _____ / _____ / _____</th>
<th>Result:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Negative ☐ Indeterminate/Borderline (repeat in 6-8 weeks) ☐ Positive (Chest X-Ray required)</td>
<td></td>
</tr>
</tbody>
</table>

**IGRA: (Specify method)**

<table>
<thead>
<tr>
<th>Method</th>
<th>Date Tested: _____ / _____ / _____</th>
<th>Result:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Negative ☐ Interstitial/Borderline (repeat in 6-8 weeks) ☐ Positive (Chest X-Ray required)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TUBERCULOSIS SKIN TEST**

<table>
<thead>
<tr>
<th>Date placed: _____ / _____ / _____</th>
<th>Date read: _____ / _____ / _____</th>
</tr>
</thead>
<tbody>
<tr>
<td>mm of induration</td>
<td>Interpretation based on mm of induration and risk factors:</td>
</tr>
<tr>
<td>☐ Negative ☐ Positive (Chest X-Ray required)</td>
<td></td>
</tr>
</tbody>
</table>

**TB BLOOD TEST**

<table>
<thead>
<tr>
<th>Date Tested: _____ / _____ / _____</th>
<th>Result:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Negative ☐ Interstitial/Borderline (repeat in 6-8 weeks) ☐ Positive (Chest X-Ray required)</td>
<td></td>
</tr>
</tbody>
</table>

**DIVISION 1 ATHLETES SICKLE CELL SCREEN RECOMMENDED**

<table>
<thead>
<tr>
<th>Sickle Cell Screen Date: MONTH _____ DAY _____ YEAR _____</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Positive ☐ Negative</td>
</tr>
</tbody>
</table>

**CLINICAL EVALUATION**

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

**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 (MM/DD/YY)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ADDRESS**

**PHONE**