ROBERTS WESLEYAN COLLEGE

# Health & Immunization Form for College Attendance – F-1 Students

Academic Year: 2 _____ ❑ Fall semester ❑ Spring semester ❑ Summer semester

❑ Undergrad Freshman ❑ Transfer Student ❑ Remit Student
❑ International Student ❑ E.L.I. Student ❑ B.E.L.L. Student
❑ Nursing ❑ Athlete-Student Sport(s) _____

To secure confidentiality, please submit the completed form and documents directly to:

1. Mail to: Health Center
   Roberts Wesleyan College
   2301 Westside Drive, Rochester, NY 14624
2. Email at healthcenter@roberts.edu (at your discretion)
3. Fax (secured line) at 585-594-6920

Incomplete information or unsigned forms will not be processed.

**Office Use Only**

**Received:** _____

**Recorded:** _____

**By Staff:** _____

**SUBMISSION DEADLINE**

One month prior to first class session or sport participation.

***Failure to comply with the New York State Public Health Law 2165 & 2167 regulations prevent clearance for attendance.***

Last name: _____ First: _____ Middle Initial: _____

Date of birth: (MM-DD-YY) ____/____/____ Sex: M ❒ F ❒ Citizenship: U.S. ❒ Other ❒ (specify) _____

Address: (street/PO box) _____

City/Town: _____ State: ____ Zip: _____ Home Phone:(____)_____-_____

Cell Phone: (____) _____- _____ Email Address: _____

## INSURANCE INFORMATION:

Last: (Primary) _____ First:_____ Middle Initial: _____
Relationship to student: _____ Primary's DOB: _____/_____/_____ Primary's Gender:_____
Insurance Company:_____
Policy No:_____ Group No:_____
Effective Date: _____/_____/_____ Termination Date: _____/_____/_____

## RELEASE OF INFORMATION / EMERGENCY CONTACT:

I give permission to the Health Center staff at Roberts Wesleyan College to discuss my health care with the individual indicated below. I, also authorize this person to be called in case of an emergency.

Name: _____ Relationship: _____

Daytime phone #: _____ Evening Phone #: _____ Cell phone #: _____

Student's signature: (required) _____ Date: _____/_____/_____

## AUTHORIZATION FOR TREATMENT

In submitting this Health and Immunization form, I attest the information is complete and accurate. I authorize Roberts Wesleyan College Health Center to provide medical treatment and services as they deem appropriate. I understand my information if pertinent may be shared to facilitate collaboration among the Athletic Department, Campus Security, Counseling Center or Learning Center staff to coordinate treatment for my comprehensive health care.

I understand that my medical records are confidential and maintained separately from my academic records. To have my medical records shared with others requires my written permission except in the event of a life-threatening and/or serious illness or injury of which the Health Center is aware, parents(s) or guardian may be notified at the discretion of the professional staff. *This authorization for treatment is active for the duration I am a student at Roberts Wesleyan College.*

**Student's signature: (required)** _____ Date: _____/_____/_____

**Parent's signature:** **(required if student is under age 18)** _____ Date: _____/_____/_____

## General History: To be completed by the student and/or parent/guardian(s)

Please give details below for any "yes" answers

| Have you had: | Y | N | | Y | N | | Y | N | | Y | N |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ADD/ADHD | | | Depression | | | Impaired Vision | | | Thyroid Disease | | |
| Alcohol/Drug Dependency | | | Diabetes | | | Irritable/spastic bowel | | | Tuberculosis | | |
| Anemia | | | Disease/Injury of Joints | | | Kidney Disease | | | Ulcerative Colitis | | |
| Anger Issues | | | Seizure disorder (specify below) | | | Kidney Infection | | | Urinary Tract Infections | | |
| Anorexia Nervosa | | | Ear/Nose/Throat Problems | | | Kidney Stones | | | Venereal Disease | | |
| Anxiety | | | Endocrine/Metabolic Disorder | | | Malaria | | | Weight Loss/Gain | | |
| Arthritis (specify below) | | | Fainting | | | Measles (specify below) | | | Allergy To: | | |
| Asthma | | | Fractures (specify below) | | | Mononucleosis | | | Penicillin | | |
| Back Problems | | | Frequent Colds or Sinusitis | | | Mumps | | | Sulfonamides | | |
| Bipolar Disorder | | | Gall Bladder Disease | | | Orthopedic Problems | | | Other (specify below) | | |
| Blood Disorders (specify) | | | Gastrointestinal/GERD/Reflux | | | Recurrent Headaches | | | Food (specify below) | | |
| Bulimia | | | Head Injury (Serious/Unconscious) | | | Rheumatic Fever | | | | | |
| Cancer | | | Heart Murmur | | | Rubella (German Measles) | | | Surgery: | | |
| Cerebral Palsy | | | Heart Palpitations | | | Scarlet Fever | | | Appendectomy | | |
| Chicken Pox | | | Hepatitis (specify below) | | | Seasonal Allergies | | | Tonsillectomy | | |
| Convulsive Disorder | | | Hernia | | | Self-harming Behavior | | | Wisdom Teeth Removed | | |
| Crohn's Disease | | | High Blood Cholesterol | | | Skin Conditions | | | Other (specify below) | | |
| Cystic Fibrosis | | | High Blood Pressure | | | Sleep Disorder | | | Last Dental Exam Date | | |
| Cystitis/bladder Infection | | | Impaired Hearing | | | Suicidal Thought/Attempts | | | | | |

**Comments and/or explanation(s):**

| Medical History (Answer all questions) | Yes | No | Explain all "yes" answers below or on an additional sheet and attach. |
|---|---|---|---|
| Do you have any drug/medication allergy? | | | |
| Do you smoke? | | | |
| Do you consume alcohol? | | | |
| Do you use recreational drugs? | | | |
| Has your physical activity been restricted during the past five years? | | | |
| Have you had any illness or injury or been hospitalized other than already noted above? | | | |
| Do you have an ongoing health problem that has required treatment by a physician or other health care provider in the past five years? | | | |
| Have you received treatment by a psychiatrist or clinical psychologist? | | | |
| Do you take medication on a regular basis? If so, please list name(s) and dosage(s). | | | |
| Do you consider yourself challenged or disabled in any way that requires you to receive special consideration from RWC? If so, please specify. | | | |

| **Student information:** | | | | | |
|---|---|---|---|---|---|
| **Name:** | | | | **Date of Birth:** | |
| **Intercollegiate Sports(s)** | | | | **Gender:** | |
| **Date of Physical:** | | | | **Year in School:** FR SO JR SR | |
| **Examination** *(Physical must be dated within a year) (Athletic physical must be dated within six months of sports participation)* | | | | | |
| **Height:** | **Weight:** | **BP:** | **Pulse:** | **BMI:** | |
| **Vision Corrected:** ❒ **Yes** ❒ **No** **L 20/** **R 20/** | | | | **Pupils: Equal / Unequal** | |

| | Normal | Abnormal or significant findings |
|---|---|---|
| General | | |
| Appearance | | |
| HEENT | | |
| Lung | | |
| Heart Murmurs, (auscultation standing, supine) | | |
| Endocrine/Lymph Nodes | | |
| Abdominal | | |
| Genialia (males only) | | |
| Pulses Radial pulses & Simultaneous femoral | | |
| Neurologic | | |
| Skin | | |
| Musculoskeletal | | |
| Neck/Shoulder/Back | | |
| Arm/Elbow/Wrist/Hand/Fingers | | |
| Leg/Hip/Thigh/Knee | | |
| Ankle/Foot/Toes | | |

Does the student have drug allergies? If yes, please list by name and type of reaction: _____

_____

Recommendations/Comments regarding the chronic condition or serious illness continuing care of the student:

_____

_____

Recommendations/Comments regarding the emotional, continuing care of the student:

_____

_____

❒ Cleared to participate in a full program college study

❒ Cleared for all sports without restrictions

❒ Cleared for all sport without restriction with recommendations for further evaluation or treatment for _____

❒ Not cleared for sports ❒ Not cleared for college study

❒ Pending further evaluation

Reason and recommendations _____

_____

**Medical provider signature/stamp or a copy of the medical provider's document must be attached.** **STAMP**

_____

MD, NP, or PA's Signature

_____

MD, NP, or PA's Printed Name

_____

Address, City, State

# REQUIRED

**Records of the following are REQUIRED for International (F-1) Students attending Roberts Wesleyan College:**

**1. NYS Public Health Law 2165 & 2167 mandates** students born after January 1, 1957 enrolled in six (6) credit hours or more to provide documented proof of immunity (vaccines or positive titer (blood test) results against measles, mumps, rubella and meningococcal meningitis disease:

**Must fully complete ONE of the following three options:**

| | | |
|---|---|---|
| **Option** 1 | MMR #1 (Measles, Mumps, Rubella) | Date: _____/_____/_____ |
| | MMR #2 (Measles, Mumps, Rubella) | Date: _____/_____/_____ |
| **Option** 2 | Measles #1 (Rubeola) | Date: _____/_____/_____ |
| | Measles #2 (Rubeola) | Date: _____/_____/_____ |
| | Mumps | Date: _____/_____/_____ |
| | Rubella (German measles) | Date: _____/_____/_____ |
| **Option** 3 | Positive Measles Titer | Date: _____/_____/_____ |
| | Positive Mumps Titer | Date: _____/_____/_____ |
| | Positive Rubella Titer | Date: _____/_____/_____ |

**2. NYSPHL Law 2167 mandates** ALL students, **regardless of age**, to provide either proof of meningococcal vaccine or a signed declination statement rejecting the meningococcal vaccine.

**Must fully complete ONE of the following two options:**

| | |
|---|---|
| **Option** 1 | Meningococcal Vaccine Type: _____ Date: _____/_____/_____ (dated within 5 yrs) |
| **Option** 2 | ***Student elected not to be immunized against meningococcal meningitis disease.*** 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 decided **NOT** to be immunized against the meningococcal meningitis disease.<br>Student's Signature: _____ Date:_____/_____/_____ |

**3. Tuberculosis Screening** (dated within a month before arriving to the states)

**Must fully complete**

| | |
|---|---|
| **ONLY Option** | PPD (Mantoux) within the past year:<br>Date placed: ____/____/____ Date read: ____/____/____ (within 48-72 hours)<br>RESULT: ____ Negative<br>____ Positive _____ mm indurations *(If positive, chest x-ray report is mandated)* |

**Medical provider signature/stamp or a copy of the medical provider's document must be attached.**

_____
MD, NP, or PA's Signature:

_____
MD, NP, or PA's Printed Name:

_____
Address, City, State:

**STAMP**

**Immunization Record:** *(must be completed and signed by medical provider or attach copy of the medical provider's record)*

**Student's Name:** _____ **Date of Birth:** _____/_____/_____

# RECOMMENDED

**The following immunizations are suggested for International (F-1) Students attending Roberts Wesleyan College:**

| | | | |
|---|---|---|---|
| **Tetanus/Diphtheria/Pertussis** | Date: _____/_____/_____ (dated within 10 years) | | |
| **Hepatitis A** | #1 Date: ____/____/____<br>#2 Date: ____/____/____ | **OR** | Positive Titer Date: ____/____/____ |
| **Hepatitis B** | #1 Date: ____/____/____<br>#2 Date: ____/____/____<br>#3 Date: ____/____/____ | **OR** | Positive Titer Date: ____/____/____ |
| **Polio Booster** | Date: ____/____/____ | | |
| **Seasonal Flu vaccine** | Date: ____/____/____ | | |
| **Varicella** | History of Varicella disease: Yes _____ No _____ Date: ____/____/____<br>#1 Date: ____/____/____<br>#2 Date: ____/____/____ | **OR** | Positive Titer Date: ____/____/____ |
| **COVID 19 Vaccine** | Pfizer #1 Date: ____/____/____ #2 Date: ____/____/____<br>Moderna #1 Date: ____/____/____ #2 Date: ____/____/____<br>Janssen #1 Date: ____/____/____<br>Other _____ #1 Date: ____/____/____ #2 Date: ____/____/____ | | |

**Medical provider signature/stamp or a copy of the medical provider's document must be attached.**

_____
MD, NP, or PA's Signature:

_____
MD, NP, or PA's Printed Name:

_____
Address, City, State:

**STAMP**