Roberts Wesleyan College

2301 Westside Drive~Rochester, NY 14624
Phone: (585) 594-6360 Fax: (585) 594-6920 HealthCenter@roberts.edu

Nursing Student - Health/Physical/Immunization Form

New or Transfer Full-time Undergrad Students
(6 credit hours or more)

Please check all that apply:	Failure to comply with the New York State Public Health Law 2165 and 2167 regulations will prevent clearance for attendance.	**Office Use Only**
Year: 2 _____ ❑ Fall semester ❑ Spring semester ❑ Summer semester ❑ Please list sport(s) _____ ❑ Undergraduate Freshman ❑ Transfer Student ❑ International Student ❑ E.L.I. Student ❑ B.E.L.L. Student	Please print clearly and submit entire form and/or attach medical records. Incomplete or unsigned forms will not be processed. **To secure and maintain confidentiality, please send all documents directly to the <u>Health Center</u> by mail, email or fax.**	**Received** _____ **Cleared by** _____ **Date** _____ Submission Date: As soon as possible, please Deadline Date: One week prior to first session and/or sport participation

Last name _____ First & middle name _____

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

Address (street/PO box) _____

City, state, zip _____

Home phone _____ Cell phone _____Email address _____

RELEASE OF INFORMATION / EMERGENCY CONTACT

I, _____ , give permission to the Health Center or other appropriate 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 emergency.

Name: _____ Relationship: _____

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

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

AUTHORIZATION FOR TREATMENT

In submitting this Health History 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 the information may be shared with Athletic Department staff and/or Counseling Center staff as/if needed, in order to facilitate collaboration among campus services 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, when parents 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 _____/_____/_____

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

	Age and state of health		Occupation	Age at death and cause (if applicable)		Have your grandparents/parents/ siblings had any of the following?	Y	N	Relationship
Father						Arthritis			
Mother						Asthma, Seasonal Allergies			
Brother(s)						Cancer			
						Diabetes			
						Epilepsy, Convulsions			
						Heart Disease / Stroke			
Sister(s)						High Blood Pressure			
						Kidney Disease			

General Health: 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					

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.			

Nursing Evaluation and Physical Form

Evaluation *(to be completed by student)*

Name_____ Birthdate _____ Age_____ FR SO JR SR

MEDICAL HISTORY	Yes	No
1. Have you ever been hospitalized?	☐	☐
Have you ever had surgery?	☐	☐
2. Are you presently taking any medications or pills?	☐	☐
3. Do you have any allergies (medicine, bees, or other stinging insects)?	☐	☐
4. Have you ever been dizzy or passed out during or after exercise?	☐	☐
Have you ever had chest pain?	☐	☐
Have you ever had high blood pressure?	☐	☐
Have you ever been told that you have a heart murmur?	☐	☐
Have you ever had racing of your heart or skipped heartbeats?	☐	☐
Has anyone in your family died of heart problems or a sudden death before age 50?	☐	☐
5. Do you have any skin problems (itching, rashes, acne)?	☐	☐
6. Have you ever had a head injury?	☐	☐
Have you ever been knocked out, unconscious, or had a seizure?	☐	☐
7. Do you have trouble breathing or do you cough frequently?	☐	☐
8. Do you use any special equipment (pads, braces, neck rolls, mouthguard, eye guards, etc.)?	☐	☐
9. Have you had any problems with your eyes or vision?	☐	☐
Do you wear glasses, contacts, or protective eyewear?	☐	☐
10. Ever had sprained/strained, dislocated, fractured, broken, repeated swelling, or other problems of bones/joints?	☐	☐
☐ Head ☐ Shoulder ☐ Thigh ☐ Neck ☐ Elbow ☐ Knee ☐ Chest ☐ Forearm		
☐ Shin/Calf ☐ Back ☐ Wrist ☐ Ankle ☐ Hip ☐ Hand ☐ Foot		
11. Any other medical problems? (mononucleosis, diabetes, kidney disease, thyroid, bleeding problems, etc.)	☐	☐
12. Any medical problems relevant to clinical practice?	☐	☐
13. Health Promotion		
Do you do self-breast exams/ self-testicular exams monthly?	☐	☐
Do you exercise three or more times a week?	☐	☐
Do you wear your seatbelt?	☐	☐
Have you or do you drink alcohol	☐	☐
Have you or do you smoke	☐	☐
Are you sexually active?	☐	☐

14. First day of your last menstrual cycle_____ Regular cycle ____ Irregular cycle ____

Explain "Yes" answers (#1-12):_____

_____

_____

I hereby state that to the best of my knowledge my answers to the above questions are correct.

_____ _____

Signature Date

Examination: ***(to be completed and signed or attached copy of the medical provider's record)***

Name _____ **Physical Date:** _____/_____/_____

Height: _____ **Weight:** _____ **BP:** _____ **Pulse:** _____ **BMI:** _____ **Vision: L 20/**_____ **R 20/** _____

	No	Yes	Note variances, abnormal or significant findings
General			
HEENT			
Neck/Endocrine			
Respiratory			
Cardiovascular			
Breast			
Abdomen			
Genitourinary			
Hernia			
Neurologic			
Skin			
Musculoskeletal			
Neck/Shoulder/Arm			
Wrist/Hand/Fingers			
Hip/Thigh/Knee			
Leg/Ankle/Foot			

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:

_____

_____

Medically cleared to participate in a full program of college study _____Yes _____ No

Medically cleared for intercollegiate athletic participation _____Yes _____ No

Limitations/Comments: _____

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

Immunization Record: ***(to be completed and signed or attached copy of the medical provider's record)***

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

1. **NYS Public Health Law 2165 mandates** students born after January 1, 1957 enrolled in six (6) credit hours or more provide documented proof of immunity against the following:

MMR #1 (Measles, Mumps, Rubella) Date _____/_____/_____ MMR #2 (Measles, Mumps, Rubella) Date _____/_____/_____

OR documentation of immunity to measles, mumps, and rubella by separate vaccines or titer (blood) tests

Measles 1 (Rubeola) Date _____/_____/_____ Positive Measles Titer Date _____/_____/_____
Measles 2 (Rubeola) Date _____/_____/_____ Positive Mumps Titer Date _____/_____/_____
Mumps Date _____/_____/_____ Positive Rubella Titer Date _____/_____/_____
Rubella (German measles) Date _____/_____/_____ History of the disease (not acceptable for rubella)

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

Meningococcal Vaccine Type: Menactra ❒ Menomune ❒ Date _____/_____/_____ (dated within 5 years)

***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.

Signature _____ Date _____/_____/_____

3. **Tuberculosis Screening** (Required for international, nursing and high risk students) (dated within one year)

PPD (Mantoux) within the past year: Date placed: ____/____/____ Date read: ____/____/____ (within 48-72 hours)

RESULT: ___ Negative ____ Positive _____ mm indurations *(If positive, chest x-ray report is required)*

RECOMMENDED IMMUNIZATIONS:

Tetanus/Diphtheria/Pertussis Date _____/_____/_____ (dated within 10 years)

Hepatitis B #1 _____/_____/_____ Hepatitis A #1 _____/_____/_____
Hepatitis B #2 _____/_____/_____ Hepatitis A #2 _____/_____/_____
Hepatitis B #3 _____/_____/_____ Hepatitis A Positive Titer Date _____/_____/_____
Hepatitis B Positive Titer Date _____/_____/_____

Polio Booster Date _____/_____/_____

History of Varicella disease Yes ____ No ____ Date _____/_____/_____
Varicella vaccine 1 _____/_____/_____
Varicella vaccine 2 _____/_____/_____ or Varicella Positive Titer Date _____/_____/_____
Seasonal Flu vaccine _____/_____/_____

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

TUBERCULOSIS (TB) SCREENING

Student Name _____ Birthdate _____ / _____ / _____

Please answer the following questions:

1. Have you ever had a positive TB skin test? Yes _____ No _____
2. Have you ever had close contact with anyone who was sick with TB? Yes _____ No _____
3. Were you born in one of the countries listed below and arrived in the U.S. within the past 5 years?
   (If yes, please circle the country) Yes _____ No _____
4. Have you ever traveled to/in one or more of the countries listed below? Yes _____ No _____
   (If yes, please check the country/ies)
5. Have you ever been vaccinated with BCG? Yes _____ No _____

If the answer is YES to any of the above questions, the student is required to have a health care provider complete a tuberculosis risk assessment (preferably completed within 6 months prior to the start of classes).

If the answer is NO to all of the above questions, no further testing or further action is required unless the student is an ***international or nursing student***.

TUBERCULOSIS (TB) RISK ASSESSMENT

Students with any of the following risk factors are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented.

1. Recent close contact with someone with infectious TB disease Yes _____ No _____
2. Foreign-born from (or travel* to/in) a high-prevalence area Yes _____ No _____
   (If Yes, please check the country/ies)
3. Fibrotic changes on a prior chest x-ray suggesting inactive or past TB disease Yes _____ No _____
4. HIV/AIDS Yes _____ No _____
5. Organ transplant recipient Yes _____ No _____
6. Immunosuppressed (equivalent of > 15 mg/day of prednisone) Yes _____ No _____
7. History of illicit drug use Yes _____ No _____
8. Resident, employee, or volunteer in a high-risk congregate setting (e.g., correctional facilities, nursing homes, homeless shelters, hospitals, and other health care facilities) Yes _____ No ____
9. Medical condition associated with increased risk of progressing to TB disease if infected [e.g., diabetes mellitus, silicosis, head, neck, or lung cancer, hematologic or reticuloendothelial disease such as Hodgkin's disease or leukemia, end stage renal disease, intestinal bypass orgastrectomy, chronic malabsorption syndrome, low body
   Yes _____ No _____

*The significance of the travel exposure should be discussed with a health care provider and evaluated.

1. Does the student have signs or symptoms of active tuberculosis disease? Yes _____ No _____

If No, proceed to 2 or 3. If Yes, proceed with additional evaluation to exclude active tuberculosis disease, including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

2. Tuberculin Skin Test (TST)

(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0". TheTST interpretation should be based on mm of induration as well as risk factors.)**

Date Given: ____/____/_____ Date Read: ____/____/_____
M D Y M D Y

Result: _____ mm of induration **Interpretation: positive _____ negative _____

Date Given: ____/____/_____ Date Read:____/____/_____
M D Y M D Y

Result: _____ mm of induration **Interpretation: positive _____ negative _____

3. Interferon Gamma Release Assay (IGRA)

Date Obtained: ____/____/_____ (specify method) QFT-G QFT-GIT T-Spot other _____
M D Y

Result: negative _____ positive _____ indeterminate _____ borderline _____ (T-Spot only)

Date Obtained: ____/____/_____ (specify method) QFT-G QFT-GIT T-Spot other _____
M D Y

Result: negative _____ positive _____ indeterminate _____ borderline _____ (T-Spot only)

4. Chest x-ray: (Required if TST or IGRA is positive)

Date of chest x-ray: ____/____/_____Result: normal _____ abnormal _____
M D Y

**Interpretation guidelines

>5 mm is positive:	>10 mm is positive:
• Recent close contacts of an individual with infectious TB • Persons with fibrotic changes on a prior chest x-ray consistent with past TB disease • Organ transplant recipients • Immunosuppressed persons: taking > 15 mg/d of prednisone for > 1 month; taking a TNF-αantagonist • Persons with HIV/AIDS *The significance of the travel exposure should be discussed with a health care provider and evaluated	• Persons born in a high prevalence country or who resided in one for a significant* amount of time • History of illicit drug use • Mycobacteriology laboratory personnel • History of resident, worker or volunteer in high-risk congregate settings • Persons with the following clinical conditions: silicosis, diabetes mellitus, chronic renal failure, leukemias and lymphomas, head, neck or lung cancer, low body weight (>10% below ideal), gastrectomy or intestinal bypass, chronic malabsorption syndromes >15 mm is positive: • Persons with no known risk factors for TB disease

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

Afghanistan
Algeria
Angola
Argentina
Armenia
Azerbaijan
Bahrain
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cambodia
Cameroon
Cape Verde
Central African Republic
Chad
China
Colombia
Comoros
Congo
Cook Islands
Côte d'Ivoire
Croatia
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
French Polynesia
Gabon
Gambia
Georgia
Ghana
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Japan
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libyan Arab Jamahiriya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Micronesia (Federated States of)
Mongolia
Montenegro
Morocco
Mozambique
Myanmar
Namibia
Nepal
Nicaragua
Niger
Nigeria
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Saint Vincent and the Grenadines
Sao Tome and Principe
Senegal
Serbia
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
Sri Lanka
Sudan
Suriname
Swaziland
Syrian Arab Republic
Tajikistan
Thailand
The former Yugoslav Republic of Macedonia
Timor-Leste
Togo
Tonga
Trinidad and Tobago
Tunisia
Turkey
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe