COLLEGE ENTRANCE HEALTH HISTORY AND PHYSICAL EXAMINATION

RETURN TO: **Purchase College Student Health Services**
735 Anderson Hill Road
Purchase, New York 10577-1402
(914) 251-6380/FAX (914) 251-6388
hse@purchase.edu

To Parents and Guardians of Students **under** Eighteen:
In order to procure quickly any emergency care that may be necessary for students and at the same time to protect the health care providers and institutions involved, it is required that you sign and have notarized the consent for emergency treatment below.

Be assured that we make every effort to notify parents at once in case of serious accidents or illnesses when these come to our attention.

I_____ pursuant to the authority vested in me as

_____ of _____ do hereby authorize the
parent-guardian student's full name
medical staff of Purchase College Student Health Service (SHS) upon consultation with a practicing physician, nurse practitioner or surgeon to exercise for me and on my behalf, all rights and duties with reference to consenting to appropriate medical, psychiatric, and surgical treatment, anesthetics, medicines and hospitalization, including care and treatment, by any hospital, or licensed health care provider for the emergency care of my child,

_____.
full name

Signed _____ Date _____

Subscribed before me this _____ day of _____ 20__

STUDENT'S CONTACT INFORMATION
ALL STUDENTS NEED TO COMPLETE THIS PART

Please print all information

Name: _____ _____ _____ **CID:** _____
last first mi (campus ID number – if known)

ADDRESS: _____ **PHONE #:** _____ **EMAIL**: _____

_____

PARENT OR GUARDIAN: _____
(in case of emergency) name

_____
address

_____
phone number

PRIMARY PHYSICIAN: _____
name

_____
phone number

Name (last, first, middle initial) _____ **DOB** _____

Health Habits (circle yes/no):

1) Have you ever used tobacco regularly? Yes No
   Do you currently smoke cigarettes? Yes No
   If yes, # per day: ___ Do you want to quit? Yes No
2) Do you exercise regularly? Yes No
   If yes, what type? _____
3) Do you drink alcohol? Yes No
   If yes, what type? _____
4) Do you use drugs? Yes No
   If yes, what type? _____
5) Do you observe a particular diet? Yes No
   If yes, what kind? _____
6) Do you visit the dentist every year? Yes No
   When was your last dental visit? _____

Family Health History: Have any close relatives (parents, siblings) ever had any of the following? (check all that apply and write below which relative the condition applies to)

- □ Alcohol/Drug Problems
- □ Allergies
- □ ADHD (Attention Deficit and Hyperactivity Disorder)
- □ Asthma
- □ Blood or clotting disorders
- □ Cancer
- □ Depression/psychiatric illness
- □ Diabetes
- □ Heart Disease
- □ Hereditary disease
- □ High blood pressure
- □ High cholesterol
- □ Stroke
- □ Tuberculosis
- □ Thyroid disorder
- □ Other serious illness
- □ Sudden death
- □ Heart attack < 50
- □ other

Explain any items checked:

_____

_____

Immunization Record: to be filled out by Healthcare Provider

RECORD INDIVIDUAL DATES OF EACH DOSE

	1ST dose	2nd dose	3rd dose	4th dose	5th dose
MMR *					
Polio Vaccine (Live oral Sabin)*					
Diphtheria & Tetanus toxoid *					
Td Booster					
Tdap					
Hepatitis A					
Hepatitis B *					
Meningococcal Vaccine (MCV4)					
Varicella					
HPV:					
Pneumococcal:					

* required

TB test (ppd or Q-Gold) required for high risk students (see attached risk assessment)

Tests done: PPD: Date _____ Result in mm. _____

And/or Q-Gold: Date _____ Result _____

If positive: Chest x-ray: Date _____ Result _____

Medication given: _____

Name (last, first, middle initial) _____ **DOB** _____

Health History: (to be filled out by student before physical examination)

Have you had or do you now have any of the following? (please check appropriate spaces and explain below)

1. Head/Neurological	Yes	No
Frequent headaches/migraines	__	__
Dizziness or fainting	__	__
Loss of consciousness	__	__
Head Injuries	__	__
Epilepsy/seizures	__	__

2. Eyes		
Vision or eye problems	__	__
Glasses or contact lenses	__	__

3. Ears/Nose/Throat		
Allergies or hay fever	__	__
Ear or hearing problems	__	__
Frequent Tonsillitis/sore throat	__	__
Speech defect	__	__

4. Skin		
Moderate/Severe acne	__	__
New or changing moles	__	__
Eczema/psoriasis	__	__
Hives	__	__

5. Infectious Disease		
Mononucleosis	__	__
Lyme Disease	__	__
HIV	__	__
Hepatitis	__	__
Chicken Pox	__	__

6. Heart/Circulation/Chest	Yes	No
Severe chest pain or pressure	__	__
Heart disease or murmur	__	__
Rapid or irregular pulse	__	__
Blood clots or vascular problems	__	__
Elevated cholesterol	__	__
High blood pressure	__	__
Congenital heart condition	__	__

7. Respiratory		
Chronic cough (over 1 month)	__	__
Pneumonia/Bronchitis	__	__
Tuberculosis or positive PPD	__	__
Shortness of breath	__	__
Asthma	__	__

8. Gastrointestinal		
Abdominal pain (severe/recurrent)	__	__
Ulcer	__	__
Intestinal problems	__	__
Blood in stool	__	__
Hernia	__	__

9. Musculoskeletal/Rheumatology		
Swollen or painful joints or extremities	__	__
Chronic or severe back problems	__	__
Fractures/dislocations	__	__
Chronic muscle pain	__	__
Arthritis	__	__
Systemic Lupus Erythematosis	__	__

10.Endocrine/Metabolic	Yes	No
Diabetes Mellitus	__	__
Thyroid Disease	__	__

11. Genitourinary		
Urinary/kidney problems	__	__
Menstrual Irregularities	__	__
Sexually Transmitted infections	__	__

12. Hematology/Oncology		
Anemia	__	__
Bleeding disorder	__	__
Cancer	__	__
Sickle Cell Disease	__	__
Sickle Cell Trait	__	__

13. Psychosocial		
Bi-polar disorder	__	__
Depression	__	__
ADHD/ADD	__	__
Anxiety/panic disorder	__	__

14. Additional Medical History		
Unusual fatigue (>1month)	__	__
Recent wt loss or gain (10 lbs + / -)	__	__
Eating disorder	__	__

15. Previous hospitalizations __ __

16. Surgeries: _____

Explain all "yes" answers from above: _____

_____

_____

Medications (List all prescription and non-prescription medications that you are currently taking):

NAME OF MEDICATION	CONDITION

Allergies: (medications, animals, food, environmental):

Reaction:

Name (last, first, middle initial): _____ **DOB:** _____

Physical Examination:

Gender ___ Age ___

Ht _____ Wt _____ BMI _____ (optional)

BP ___ / ___ P ___ LMP: _____

Vision R 20 / _____ L 20 / _____ Corrected ___ No ___ Yes Glasses/Contacts Red/Green _____

Sickle Cell Blood Test: Neg ___ Trait ___ Disease ___
(athletes only)

Comments _____

(4) MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Skin		
Head, eyes, ears, nose, throat, teeth		
Lymph nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Neuro		

(5) MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder, arm		
Elbow, forearm		
Wrist, hand		
Hip, thigh		
Knee		
Leg, ankle		
Foot		

Any evidence of emotional instability? _____

General health recommendations _____

_____

Physical Education/Intercollegiate/Club Sports Participation:

Sport(s) participating in _____

□ cleared □ cleared/with coach notification □ deferred clearance □ not cleared

Explain _____

_____

Healthcare Provider:

Name (print): _____ Date: _____

Signature: _____

Address: _____

_____ Telephone: _____

TO BE FILLED OUT BY STUDENT

Name: _____
Date:_____ Age____ Date of Birth_____

PURCHASE COLLEGE STUDENT HEALTH SERVICE
TARGETED TESTING FOR LATENT TUBERCULOSIS INFECTION (LTBI)
RISK ASSESSMENT QUESTIONNAIRE (RAQ)

This questionnaire is given to all students entering SUNY Purchase College, for the purpose of determining your need for a skin test for screening for Tuberculosis (TB). Please answer all questions to the best of your ability, and then give the form to your physician along with your Physical Exam Form.

1. In what country were you born? _____
If you were born outside of the USA, when did you move here? _____/_____ (month/year)

2. Have you visited or lived in any countries other than the USA for one month or more?
____NO
____YES Which countries?_____

Did you stay with people who have lived/worked in that country for one month or more?
____No __Yes
Were you studying or working in a health-care, or disaster-relief capacity? ___No ___Yes

3. Have you ever lived, volunteered or worked in a prison or jail, nursing home, hospital or other health-care facility, residential facility for people with AIDS or HIV infection, homeless shelter or drug-treatment facility and had contact with the patients or residents?
____No ____Yes (Where/when/ in what capacity?)_____

4. Will you be working, doing a rotation, or interning in one of the above facilities, or in a microbiology lab in the coming year?
____No ____Yes (Where?)_____

5. Have you ever lived, worked, or been in close contact with a person with active TB, including when you were a child?
____No ____Yes (Where/when?) _____

6. Do you have any of the following conditions? ____No ____Yes

Chronic Renal Failure	Organ transplant recipient
Diabetes	Corticosteroid therapy (Prednisone $\geq$ 15mg/d for at least
Leukemias or lymphomas	1 month.) or other immunosuppressive disorders
Low body weight or malnutrition	HIV infection or AIDS
Chronic malabsorption syndromes	Receiving immunosuppressive therapy, e.g., Remicade
Gastrectomy and/or jejunoileal by-pass	Injection drug use

All answers are true to the best of my knowledge. I understand that this questionnaire will remain part of my confidential medical record. This information may be released only with my written consent or under subpoena from a court of law.

Signature_____ Date:_____

TO BE FILLED OUT BY HEALTH CARE PROVIDER

Student Name:_____ **DOB**_____ **Date:**_____

PURCHASE COLLEGE STUDENT HEALTH SERVICE
LATENT TUBERCULOSIS INFECTION (LTBI)
RISK DETERMINATION FOR TARGETED TESTING

The Centers for Disease Control (CDC,) the American Thoracic Association (ATA,) and the American College Health Association (ACHA) have recommended that in populations with a low overall probability of risk for infection with Tuberculosis, **targeted testing for Latent Tuberculosis Infection (LTBI) be done only on those persons deemed to be at high risk for infection with TB.** Please use the completed Risk Assessment Questionnaire (RAQ) to answer the following questions. If the student has not filled out the form, please fill it out with him/her in order to determine risk status as defined below. **Please return this form to Purchase College Health Services along with the Physical Exam Form and the Student's RAQ.**

DETERMINATION OF THE STUDENT'S RISK STATUS IS BASED ON THE FOLLOWING CRITERIA:

High Risk: On **#1**, the country is **high risk**, and the student has lived in the USA for **≤ five years**. Answered "**yes**" to 1 or more questions on the attached RAQ questionnaire, **unless** the country is low risk (see below) or

Low Risk: Answered **"no"** to **all of the questions** on the attached questionnaire, ***or***
Answered **"yes" to #2** *and* **the country is low risk,** (see below) ***or***
On **#1** the country is **high risk** but the student has lived in the USA **≥ five years**.

Low Risk Countries:

Albania, Andorra, Antigua, Aruba, Bahrain and Barbuda, Bermuda, Bonaire, Saint Eustatius and Saba, Australia, Austria, Bahamas, Barbados,Belgium, British Virgin Islands, Canada, Cayman Islands, Chile, Cook Islands, Costa Rica, Croatia, Cuba, Curacao, Cyprus, Czech Republic, Denmark, Domenica, Egypt, Estonia, Finland, France, Germany, Greece, Grenada,Hungary, Iceland, Iran (Islamic Republic of), Ireland, Israel, Italy, Jamaica, Japan, Jordan, Lebanon, Luxembourg, Macedonia (Yugoslav Republic of), Malta, Mauritius, Monaco, Montenegro, Montserrat, Netherlands, New Caledonia, New Zealand, Norway, Oman, Puerto Rico, Saint Kitts and Nevis, Saint Lucia, Samoa, San Marino, Saudi Arabia, Serbia, Seychelles, Sint Maarten (Dutch part), Slovakia, Slovenia, Spain, Sweden, Switzerland, Syrian Arab Republic, Tokelau, Tonga, Trinidad and Tobago, Turkey, Turks and Caicos Islands, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, United States of America, US Virgin Islands, Wallis and Futuna Islands and WestBank and GazaStrip

ASSESSMENT OF RISK BASED ON EVALUATION OF THE RAQ: ____**Low** ____**High**

If "High Risk" please proceed with placement of the Tuberculin Skin Test
Use only the Mantoux Test- 0.1cc purified protein derivative (**PPD**) intradermally on the volar surface of the forearm.
Please note: 1. If you have documented proof that the patient has had a **prior POSITIVE PPD, do not repeat** the PPD, but please record the size in mm, and
2. All students previously vaccinated with **BCG should still have a PPD** placed if they are in a high risk category

Signature of Health Care Provider _____ Date:_____