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 witnessed 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 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 _____

I attest that the signature on this document is authentic.

Witness _____
Name

_____
Signature

Witness _____
Name

_____
Signature

COLLEGE PRE-ENTRANCE HEALTH HISTORY AND PHYSICAL EXAMINATION
STUDENT CONTACT INFORMATION

PLEASE PRINT INFORMATION

Name: _____ _____ ___ CID: _____
Last *First* *MI* *(campus ID number if known)*

Date of Birth (DOB): _____ **Preferred name:** _____ **Preferred pronouns:** _____

Address: _____ **Cell #:** _____

_____

Parent/Guardian:

1). Name: _____ **2). Name:** _____

Address: _____ **Address:** _____

_____ _____

Cell #: _____ **Cell#:** _____

In case of emergency, contact:

1). Name: _____ **2). Name:** _____

Relationship: _____ **Relationship:** _____

Cell #: _____ **Cell #:** _____

Email: _____ **Email:** _____

Primary Healthcare Provider:

Name: _____

Address: _____

_____

Phone #: _____ **Fax #:** _____

Specialist Healthcare Provider (if any):

1). Name: _____ **2). Name:** _____

Address: _____ **Address:** _____

_____ _____

Phone #: _____ **Fax#** _____ **Phone#:** _____ **Fax#** _____

Psychiatrist/mental health provider (if any):

Name: _____

Address: _____

_____

Phone #: _____ **Fax #:** _____

Name (last, first, middle initial) _____ Date of Birth_____

Health History: (to be filled out by student)

Check all conditions that you have had in the past or that you have now

Head/Neurological
Concussion ☐
Dizziness or fainting ☐
Epilepsy/seizures ☐
Head Injuries ☐
Headaches (frequent)/migraines ☐
Loss of consciousness ☐
Other ☐

Eyes
Glasses or contact lenses ☐
Vision or eye problems ☐
Other ☐

Ears/Nose/Throat
Ear or hearing problems ☐
Seasonal Allergies ☐
Speech Problems ☐
Tonsillitis/sore throat (frequent) ☐
Other ☐

Skin
Acne (moderate/severe) ☐
Eczema ☐
Hives ☐
Moles (new or changing) ☐
Psoriasis ☐
Other ☐

Infectious Disease
Chicken Pox ☐
Hepatitis ☐
HIV ☐
Long COVID-19 ☐
Lyme Disease ☐
Mononucleosis ☐
Other ☐

Heart/Circulation
Blood clots/vascular problems ☐
Chest pain or pressure (severe) ☐
Congenital Heart Condition ☐
Elevated cholesterol ☐
Heart Disease or murmur ☐
High blood Pressure ☐
POTS ☐
Rapid or irregular pulse ☐
Other ☐

Respiratory
Asthma ☐
Chronic cough (over 1 month) ☐
Pneumonia/bronchitis ☐
Shortness of breath ☐
Tuberculosis or positive PPD ☐
Other ☐

Gastrointestinal
Abdominal pain (severe/recurrent) ☐
Acid reflux/GERD ☐
Blood in stool ☐
Hernia ☐
Intestinal problems ☐
Ulcer ☐
Other ☐

Musculoskeletal/Rheumatology
Arthritis ☐
Chronic muscle pain ☐
Chronic or severe back problems ☐
Fractures/dislocations ☐
Swollen or painful joints/extremities ☐
Systemic Lupus Erythematosus ☐
Other ☐

Endocrine/Metabolic
Diabetes Mellitus ☐
Thyroid disease ☐
Unusual fatigue (> 1 month) ☐
Weight loss (recent +/- 10 lbs.) ☐
Other ☐

Genitourinary
Menstrual Irregularities ☐
Sexually transmitted infections ☐
Vaginitis (yeast/BV) ☐
Urinary/kidney problems ☐
Other ☐

Hematology/Oncology
Anemia ☐
Bleeding Disorder ☐
Cancer ☐
Sickle Cell Disease or trait ☐
Other ☐

Psychosocial
ADHD/ADD ☐
Anxiety/panic disorder ☐
Bi-polar Disorder ☐
Depression ☐
Eating Disorder ☐
Gender Affirming Therapy ☐
Learning Disorder ☐
Other ☐

Previous hospitalizations:

_____

Surgeries: _____

Explain all checked answers from above:

_____

_____

_____

Name (last, first, middle initial) _____ Date of Birth _____

Medications

List all prescription (including birth control) and non-prescription medications, vitamins and herbal supplements that you are currently taking.

Name	Dose	How Often	Condition

Allergies

List all allergies to medications, food, products, animals, environmental:

Do you have an Epi-pen? Yes / No

Allergic to	Reaction

Name (last, first, middle initial) _____ **Date of Birth**_____

Personal Health (circle yes/no):

1) Do you smoke tobacco? Yes No
   If yes, # of cigarettes or packs per day? ____
   How many years smoking? ____ Do you want to quit? Yes No
2) Do you chew tobacco? Yes No
   If yes, How much per day? ____
   How many years chewing? ____ Do you want to quit? Yes No
3) Do you vape? Yes No
   If yes, what substance? ____
   How Often? Multiple times per day ___ Daily ___ Some days ___
   Less than once per month __ Do you want to quit? Yes No
4) Do you drink alcohol? Yes No
   If yes, what type? _____
   How often? ____ How much in one setting? ____ Do you want to quit? Yes No
5) Do you use recreational drugs? Yes No
   If yes, what type? _____ How much_____ How often? _____
   Do you want to quit? Yes No
6) Do you exercise regularly? Yes No
   If yes: What type? _____ How often? _____
7) Do you observe a particular diet? If yes: What kind? _____ How long? _____ Yes No
8) Do you visit the dentist every year? If no, when was your last visit? _____ Yes No

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

Alcohol/Drug Problems ☐ _____

Allergies ☐ _____

ADHD (Attn. Deficit & Hyperactivity Disorder) ☐ _____

Asthma ☐ _____

Blood or clotting disorders ☐ _____

Cancer ☐ _____

Depression/mental illness ☐ _____

Diabetes ☐ _____

Heart Disease ☐ _____

Hereditary disease ☐ _____

High blood pressure ☐ _____

High cholesterol ☐ _____

Stroke ☐ _____

Tuberculosis ☐ _____

Thyroid disorder ☐ _____

Sudden death ☐ _____

Heart attack < 50 ☐ _____

other ☐ _____

Added Comments: _____

_____

_____

MMR IMMUNIZATION RECORD

REQUIRED FORM

PLEASE RETURN TO:
Purchase College Student Health Service
735 Anderson Hill Road, CCS LL
Purchase, New York 10577-1402
(914) 251-6380
FAX (914) 251-6388
Upload to https://purchase.medicatconnect.com
Email to hse@purchase.edu

Name_____ CID#_____ Date of Birth_____

Permanent Address_____

New York State Public Health Law #2165 requires post-secondary students to show protection against Measles, Mumps and Rubella.

-Documentation must include month, day, and year.

Persons born prior to January 1, 1957 are exempt from this requirement.

REQUIRED IMMUNIZATIONS:

Vaccine	**Date: M/D/Y**	**Date: M/D/Y**
MMR (Measles, Mumps, Rubella) Two doses required (1st dose no more than four days prior to the first birthday, 2nd dose at least 28 days after the 1st)		
OR		
Measles Two doses required as above		
Mumps One dose no more than four days prior to the first birthday		
Rubella One dose no more than four days prior to the first birthday		
OR		
Blood Titers (Please include documentation)		
Measles		
Mumps		
Rubella		

Name of Health Care Provider

Signature of Health Care Provider (required) Date

Name (last, first, middle initial): _____ Date Of Birth: _____
Last First

Immunization Record: to be filled out by Healthcare Provider or attach official Vaccination Record

RECORD INDIVIDUAL DATES (month.day.year) OF EACH DOSE

	1ST dose	2nd dose	3rd dose	4th dose	5th dose
MMR (**required**)					
COVID – 19 (strongly recommended) (include manufacturer)					
Diphtheria, Tetanus, Acellular Pertussis (DTaP, DT)					
Hepatitis A					
Hepatitis B					
HPV (Human Papillomavirus)					
Meningococcal (MenACWY, Menactra, Menveo, Men-Quadfi)					
Meningococcal Serogroup B (Men B – Bexsero, Trumenba)					
Pneumococcal Conjugate (PCV13)					
Pneumococcal Polysaccharide (PPSV23)					
Polio (Inactivated) (IPV)					
TD, Tdap					
Varicella					

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:** _____

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: _____ DOB _____ Date _____

TARGETED TESTING FOR TUBERCULOSIS INFECTION (TBI)
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 disease. 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 Tuberculosis Disease, including when you were a child?
____No ____Yes (Where/when?) _____

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

Chronic Renal Failure	Receiving immunosuppressive drug therapy following organ transplant
Diabetes Mellitus	Corticosteroid therapy (Prednisone $\geq$ 15mg/d for at least 1 month.)
Leukemias or lymphomas	
Low body weight or malnutrition	HIV infection or AIDS
Chronic malabsorption syndromes	Receiving immunosuppressive therapy such as tumor necrosis factor (TNF) antagonists, like Humira (adalimumab), Enbrel (etanercept), Remicade (infliximab), Cimzia (adalimumab) Or Simponi (golimumab).
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
TUBERCULOSIS INFECTION (TBI)
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 Tuberculosis Infection (TBI) 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, American Samoa, Andorra, Anguilla, Antigua & Barbuda, Argentina, Armenia, Aruba, Australia, Austria, Bahamas, Bahrain, Barbados, Belarus, Belgium, Belize, Bermuda, Bosnia & Herzegovina, British Virgin Islands, Bulgaria, Cabo Verde, Canada, Cayman Islands, Chile, Colombia, Comoros, Cook Islands, Costa Rica, Croatia, Cuba, CuraÃ§ao, Cyprus, Czechia, Denmark, Dominica, Egypt, Estonia, Finland, France, French Polynesia, Germany, Greece, Grenada, Guam, Guatemala, Honduras, Hungary, Iceland, Iran, Islamic Republic of, Iraq, Ireland, Israel, Italy, Jamaica, Japan, Jordan, Kuwait, Latvia, Lebanon, Lithuania, Luxembourg, Maldives, Malta, Mauritius, Mexico, Monaco, Montenegro, Montserrat, Netherlands, New Caledonia, New Zealand, Niue, North Macedonia, Norway, Oman, Palau, Panama, Poland, Portugal, Puerto Rico, Qatar, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Samoa, San Marino, Saudi Arabia, Serbia, Seychelles, Sint Maarten (Dutch Part), Slovakia, Slovenia, Spain, Suriname, Sweden, Switzerland, Syrian Arab Republic, Togo, Trinidad & Tobago, Tunisia, Turkey, Turks & Caicos Islands, United Arab Emirates, United Kingdom of Great Britain & Northern Ireland, United States of America, Uruguay, Vanuatu, Wallis & Futuna Islands and Occupied Palestinian territory, including east Jerusalem

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
2. All students previously vaccinated with **BCG should have an IGRA blood test** if they are in a high-risk category

Signature of Health Care Provider _____ Date: _____