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: _____

Part I: Tuberculosis (TB) Screening Questionnaire (to be completed by incoming students)

Please answer the following questions:

Have you ever had close contact with persons known or suspected to have active TB disease? ❑ Yes ❑ No

Were you born in one of the countries or territories listed below that have a high incidence of active TB disease? (If yes, please CIRCLE the country, below.) ❑ Yes ❑ No

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
China, Hong Kong SAR
China, Macao SAR
Colombia
Comoros
Congo
Congo (Democratic Republic of)
Cote d'Ivoire
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Eswatini
Ethiopia
Fiji
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Korea (Democratic People's Republic of)
Korea (Republic of)
Kyrgyzstan
Lao People's Democratic Republic
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mexico
Micronesia (Federated States of)
Moldova (Republic of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Niue
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Qatar
Romania
Russian Federation
Rwanda
Sao Tome and Principe
Senegal
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Tajikistan
Tanzania (United Republic of)
Thailand
Timor-Leste
Togo
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence. Countries with average incidence rates of ≥ 20 cases per 100,000 population.

Have you resided in or traveled to one or more of the countries or territories listed above for a period of one to three months or more? (If yes, CHECK the countries or territories, above) ❑ Yes ❑ No

Have you been a resident, volunteer, and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? ❑ Yes ❑ No

Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease? ❑ Yes ❑ No

Have you ever been a member of any of the following groups that may have an increased incidence of latent *M. tuberculosis* infection or active TB disease: medically underserved, low-income, or using drugs or alcohol? ❑ Yes ❑ No

If you answered YES to any of the above questions, [insert your college/university name] [recommends or requires] that you receive TB testing prior to the start of your first enrolled term). The significance of any travel exposure should be reviewed with a health care provider.

If the answer to all the above questions is NO, no further testing or further action is required.

Part II. Clinical Assessment by Health Care Provider

Clinicians should review and verify the information in Part I. Persons answering YES to any of the questions in Part I are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA) unless a previous positive test has been documented.

History of a positive TB skin test or IGRA blood test? (If yes, document below) **Yes_____No**

History of BCG vaccination? (If yes, consider IGRA if possible.) **Yes_____No**

1. TB Symptom Check

Does the student have signs or symptoms of active pulmonary tuberculosis disease? Yes _____No

If no, proceed to 2 or 3.

If yes, check below:

❑ Cough (especially if lasting for 3 weeks or longer) with or without sputum production
❑ Coughing up blood (hemoptysis)
❑ Chest pain
❑ Loss of appetite
❑ Unexplained weight loss
❑ Night sweats
❑ Fever

Proceed with additional evaluation to exclude active tuberculosis disease including chest x-ray (PA and lateral) and sputum evaluation as indicated.

2. Interferon Gamma Release Assay (IGRA)

Date Obtained:_____/_____/_____ (specify method) QFT T-Spot other_____
M D Y

Result: negative____ positive____ indeterminate____ borderline____(T-Spot only)

Date Obtained: _____/_____/_____ (specify method) QFT T-Spot other_____
M D Y

Result: negative____ positive____ indeterminate____ borderline____(T-Spot only)

3. Tuberculin Skin Test (TST)

(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0". The TST 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_____

****Interpretation guidelines:**

Equal to or greater than 5 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 and other immunosuppressed persons (including receiving equivalent of >15 mg/d of prednisone for >1 month.) • HIV-infected persons
Equal to or greater than 10 mm is positive:	• Foreign born or travelers to the U.S. from high prevalence areas or who resided in one for a significant* amount of time • Injection drug users • Mycobacteriology laboratory personnel • Residents, employees, or volunteers in high-risk congregate settings • Persons with medical conditions that increase the risk of progression to TB disease including silicosis, diabetes mellitus, chronic renal failure, certain types of cancer (leukemias and lymphomas, cancers of the head, neck, or lung), gastrectomy or jejunoileal bypass and weight loss of at least 10% below ideal body weight **The significance of the travel exposure should be discussed with a health care provider and evaluated.*
Equal to or greater than 15 mm is positive:	• Persons with no known risk factors for TB who, except for certain testing programs required by law or regulation, would otherwise not be tested.

4. Chest x-ray: (Required if IGRA or TST is positive. Note: a single PA view is indicated in the absence of symptoms.)

Date of chest x-ray: _____/_____/_____ Result: normal_____abnormal_____
M D Y

Part III. Considerations for Treatment of LTBI

In deciding whether to recommend treatment of LTBI to individual patients, the clinician should weigh the likelihood of infection, the likelihood of progression to active tuberculosis infection, and the benefit of therapy. Students in the following groups are at increased risk of progression from LTBI to active TB disease and should be prioritized to begin treatment as soon as possible.

- ❑ Infected with HIV
- ❑ Recently infected with *M. tuberculosis* (within the past 2 years)
- ❑ History of untreated or inadequately treated TB disease, including persons with fibrotic changes on chest radiograph consistent with prior TB disease
- ❑ Receiving immunosuppressive therapy such as tumor necrosis factor-alpha (TNF) antagonists, systemic corticosteroids equivalent to/greater than 15 mg of prednisone per day, or immunosuppressive drug therapy following organ transplantation
- ❑ Diagnosed with silicosis, diabetes mellitus, chronic renal failure, leukemia, or cancer of the head, neck, or lung
- ❑ Have had a gastrectomy or jejunoileal bypass
- ❑ Weigh less than 90% of their ideal body weight
- ❑ Cigarette and e-cigarette smokers and persons who abuse drugs and/or alcohol

END OF SAMPLE FORM

If reproduced for use by a college or university health center, please insert your health center's contact information. You are encouraged to modify the form to suit your needs or requirements. This form should not be returned to ACHA.