# 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
Parent or guardian

Parent or guardian of _____ do hereby authorize the
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,

_____.
Student's 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.*

(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:_____/_____/_____ (M D Y) Date Read:_____/_____/ (M D Y)

Result: _____mm of induration **Interpretation: positive_____negative_____

Date Given:_____/_____/_____ (M D Y) Date Read:_____/_____/ (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<br>• Persons with fibrotic changes on a prior chest x-ray, consistent with past TB disease<br>• Organ transplant recipients and other immunosuppressed persons (including receiving equivalent of >15 mg/d of prednisone for >1 month.)<br>• 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<br>• Injection drug users<br>• Mycobacteriology laboratory personnel<br>• Residents, employees, or volunteers in high-risk congregate settings<br>• 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<br>**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: _____/_____/_____ (M D Y) Result: normal____abnormal_____