

Information you provide will not be used to influence your situation at this University; it will be used, if necessary, solely as an aid to providing necessary health care while you are a student. This information is strictly for the use of the Health Services, and will not be released to anyone without your knowledge and consent.

**- PLEASE RETURN BY AUGUST 1<sup>ST</sup> -**

**COLGATE UNIVERSITY HEALTH SERVICES, 13 Oak Drive, Hamilton, NY 13346 315 / 228-7750 FAX 315/228-6823**

**REPORT OF MEDICAL HISTORY**

Please complete this form before going to your physician for an examination (please print)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Country (If not U.S.A.) \_\_\_\_\_ Zip + 4 \_\_\_\_\_

Sex:  Male  Female Date of Birth (Month / Day / Year) \_\_\_\_/\_\_\_\_/\_\_\_\_ Colgate Class Year \_\_\_\_\_

Mother: Name \_\_\_\_\_ Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Father: Name \_\_\_\_\_ Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

**FAMILY HISTORY:** Adopted  Yes  No

Have any of your relatives ever had any of the following

	Age	State of Health	Occupation	Age of Death	Cause of Death
Father					
Mother					
Brothers					
Sisters					

	Yes	No	Relationship
Diabetes			
Kidney Disease			
Heart Disease			
High Blood Pressure			
Arthritis			
Cancer			
Epilepsy/Other Neuro			

**PERSONAL HISTORY: PLEASE ANSWER ALL QUESTIONS.** Comment on all positive answers in space below or on the back of this sheet.

<table border="0"> <tr> <td><b>Have you had?</b></td> <td>Yes</td> <td>No</td> <td></td> <td>Yes</td> <td>No</td> <td></td> <td>Yes</td> <td>No</td> </tr> <tr> <td>Measles</td> <td></td> <td></td> <td>Insomnia</td> <td></td> <td></td> <td>Seizures</td> <td></td> <td></td> </tr> <tr> <td>German Measles</td> <td></td> <td></td> <td>Frequent Anxiety</td> <td></td> <td></td> <td>Weakness/Paralysis</td> <td></td> <td></td> </tr> <tr> <td>Mumps</td> <td></td> <td></td> <td>Frequent Depression</td> <td></td> <td></td> <td>Chronic Cough</td> <td></td> <td></td> </tr> <tr> <td>Chicken Pox</td> <td></td> <td></td> <td>Nervousness</td> <td></td> <td></td> <td>Shortness of Breath</td> <td></td> <td></td> </tr> <tr> <td>Malaria</td> <td></td> <td></td> <td>Recurrent Headaches</td> <td></td> <td></td> <td>Hay Fever</td> <td></td> <td></td> </tr> <tr> <td>Tuberculosis</td> <td></td> <td></td> <td>Head Injury</td> <td></td> <td></td> <td>Asthma</td> <td></td> <td></td> </tr> <tr> <td>Mononucleosis</td> <td></td> <td></td> <td>w/Unconsciousness</td> <td></td> <td></td> <td><b>ALLERGY TO:</b></td> <td></td> <td></td> </tr> <tr> <td>Gum/Tooth Trouble</td> <td></td> <td></td> <td>Fainting Spells</td> <td></td> <td></td> <td>Penicillin</td> <td></td> <td></td> </tr> <tr> <td>Sinusitis</td> <td></td> <td></td> <td><b>SURGERY:</b></td> <td></td> <td></td> <td>Sulfa</td> <td></td> <td></td> </tr> <tr> <td>Eye Trouble</td> <td></td> <td></td> <td>Appendectomy</td> <td></td> <td></td> <td>Aspirin</td> <td></td> <td></td> </tr> <tr> <td>Ear Infections</td> <td></td> <td></td> <td>Tonsillectomy</td> <td></td> <td></td> <td>Insect Bites</td> <td></td> <td></td> </tr> <tr> <td>Throat Infections</td> <td></td> <td></td> <td>Hernia Repair</td> <td></td> <td></td> <td>Foods (which)</td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td>Other (explain)</td> <td></td> <td></td> <td>Other (explain)</td> <td></td> <td></td> </tr> </table>	<b>Have you had?</b>	Yes	No		Yes	No		Yes	No	Measles			Insomnia			Seizures			German Measles			Frequent Anxiety			Weakness/Paralysis			Mumps			Frequent Depression			Chronic Cough			Chicken Pox			Nervousness			Shortness of Breath			Malaria			Recurrent Headaches			Hay Fever			Tuberculosis			Head Injury			Asthma			Mononucleosis			w/Unconsciousness			<b>ALLERGY TO:</b>			Gum/Tooth Trouble			Fainting Spells			Penicillin			Sinusitis			<b>SURGERY:</b>			Sulfa			Eye Trouble			Appendectomy			Aspirin			Ear Infections			Tonsillectomy			Insect Bites			Throat Infections			Hernia Repair			Foods (which)						Other (explain)			Other (explain)			<table border="0"> <tr> <td>Palpitations (Heart)</td> <td>Yes</td> <td>No</td> <td>Urine Infection</td> <td>Yes</td> <td>No</td> </tr> <tr> <td>High Blood Pressure</td> <td></td> <td></td> <td>Protein/Sugar in Urine</td> <td></td> <td></td> </tr> <tr> <td>Heart Murmur</td> <td></td> <td></td> <td>Venereal Disease</td> <td></td> <td></td> </tr> <tr> <td>Rheumatic Fever</td> <td></td> <td></td> <td>Disease/Injury of Joints</td> <td></td> <td></td> </tr> <tr> <td>Recent Gain or Loss of Weight</td> <td></td> <td></td> <td>Back Problems</td> <td></td> <td></td> </tr> <tr> <td>Hepatitis</td> <td></td> <td></td> <td>Tumor/Cancer (explain)</td> <td></td> <td></td> </tr> <tr> <td>Stomach or Intestinal Trouble</td> <td></td> <td></td> <td><b>FEMALES ONLY:</b></td> <td></td> <td></td> </tr> <tr> <td>Gallbladder Trouble</td> <td></td> <td></td> <td>Irregular Periods</td> <td></td> <td></td> </tr> <tr> <td>Recurrent Diarrhea</td> <td></td> <td></td> <td>Severe Cramps</td> <td></td> <td></td> </tr> <tr> <td>Hernia</td> <td></td> <td></td> <td>Excessive Flow</td> <td></td> <td></td> </tr> <tr> <td>Acne (on medication)</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>	Palpitations (Heart)	Yes	No	Urine Infection	Yes	No	High Blood Pressure			Protein/Sugar in Urine			Heart Murmur			Venereal Disease			Rheumatic Fever			Disease/Injury of Joints			Recent Gain or Loss of Weight			Back Problems			Hepatitis			Tumor/Cancer (explain)			Stomach or Intestinal Trouble			<b>FEMALES ONLY:</b>			Gallbladder Trouble			Irregular Periods			Recurrent Diarrhea			Severe Cramps			Hernia			Excessive Flow			Acne (on medication)					
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**REMARKS OR ADDITIONAL INFORMATION:** Use other side of this page or attach an additional sheet.

	No	Yes (Specify)	<b>SPECIAL NEEDS</b>
Has your physical activity been restricted during the past five years?			Do you believe that you have any special needs that the University should consider, in order to provide assistance with living and learning conditions? <input type="checkbox"/> Hearing <input type="checkbox"/> Allergies <input type="checkbox"/> Motor Deficits <input type="checkbox"/> Dietary <input type="checkbox"/> Vision <input type="checkbox"/> Learning <input type="checkbox"/> Speech <input type="checkbox"/> Psychological <input type="checkbox"/> Other  Describe: _____ _____ _____ Lynn Waldman, Director of Disability Services, is available to discuss your concerns. Phone 315/228-7225 or e-mail LWaldman@mail.colgate.edu.
Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem?			
Have you been hospitalized other than already noted?			
Do you have any concerns about eating or weight?			
Are you currently on any long-term medication?			
Do you currently get allergy shots?			

Student's Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's Signature (Acknowledging Review) \_\_\_\_\_ Date \_\_\_\_\_

REPORT OF HEALTH EVALUATION

TO THE EXAMINING PHYSICIAN: Please review the student's history and complete the physician's form. Please comment on all positive answers.

THIS STUDENT HAS BEEN ACCEPTED. The information supplied will not affect the student's status: it will be used only as a background for providing health care, if this is necessary. This information is strictly for the use of the Health Services and will not be released without student consent.

Last Name First Name Middle Name SEX: M F

BP / Height (Inches) Weight (Pounds)
Uncorrected Vision: Right 20/ Left 20/ If Indicated: Urinalysis: Sugar Protein
Corrected Vision: Right 20/ Left 20/ Hemoglobin: gms %

Are there abnormalities of the following systems? If yes, describe fully. Use an additional sheet of paper if necessary.

- Yes No 1.) Head, Ears, Nose or Throat:
Yes No 2.) Eyes:
Yes No 3.) Respiratory:
Yes No 4.) Cardiovascular:
Yes No 5.) Gastrointestinal:
Yes No 6.) Hernia:
Yes No 7.) Genitourinary:
Yes No 8.) Musculoskeletal:
Yes No 9.) Metabolic/Endocrine:
Yes No 10.) Neuropsychiatric:
Yes No 11.) Skin:

Have you any general comments:

If you answer yes to any of the following questions, please give further details.
Is there loss or seriously impaired function of any paired organ? Yes No

Recommendations for physical activity (PE, Intramurals). Unlimited Limited, Explain:

Do you have any recommendation regarding the care of this student? Yes No

Physician's Name (Please Print) Phone:
Address:

Physician's Signature: Date:

Return all information to: Director, Colgate Health Services, Colgate University, 13 Oak Drive, Hamilton, NY 13346 By August 1st
This area is for additional information from reverse side of form:

### IMMUNIZATION RECORD

Immunity is required prior to registration. Please complete and return this form.

#### PART I — TO BE COMPLETED BY STUDENT (Please Print)

Name \_\_\_\_\_  
Last First M.I.

Date of Birth (Month / Day / Year) \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security # \_\_\_\_/\_\_\_\_/\_\_\_\_ Colgate Class Year \_\_\_\_

New York State Public Health Law requires that all students born after December 31, 1956 be adequately immunized. *You are legally required to provide this information and to get the necessary immunizations, or you will be DENIED enrollment.* If you qualify for a medical, religious or personal exemption, please complete Part III.

#### PART II — TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER, GIVE MONTH, DAY & YEAR.

If convenient, you may attach a signed copy of your immunization records, which must include all previous and recent shots.

**A. M.M.R. (Measles, Mumps, Rubella) (Two doses required.)**

- 1. Dose 1 given at age 12-15 months or later.
- 2. Dose 2 given at age 4-6 years or later, and at least one month after first dose.

**B. Tetanus-Diphtheria (Primary series with DtaP or DTP and booster with Td in the last ten years meets requirement.)**

- 1. Primary series of four doses with DtaP or DTP: #1  #2  #3  #4
- 2. Tetanus-Diphtheria (Td) booster within the last ten years

**C. Polio (Primary series in childhood meets requirement; three primary series schedules are acceptable.)**

- 1. OPV alone (oral Sabin): #1  #2  #3  #4
- 2. IPV alone (injected Salk): #1  #2  #3  #4
- 3. IPV/OPV sequential: #1  #2  #3  #4
- IPV Booster (If recommended for travel)

**D. Varicella (Either a history of chicken pox, a positive Varicella antibody, or two doses of vaccine given at least one month apart if immunized after age 13 years, meets the requirement.)**

- 1. History of Disease: No \_\_\_\_ OR Yes \_\_\_\_ (include date)
- 2. Varicella antibody: Non-reactive \_\_\_\_ OR Reactive \_\_\_\_ (include date)
- 3. Immunization: #1  #2 (given at least one month after first dose if age 13 years or older)

**E. Hepatitis B (Three doses of vaccine or a positive Hepatitis surface antibody meets the requirement.)**

- 1. Immunization: #1  #2  #3
- 2. Hepatitis B surface antibody: Non-reactive \_\_\_\_ OR Reactive \_\_\_\_ (include date)

**F. Meningococcal (One dose - preferably at entry into college for students living in dormitories or residence halls who wish to reduce their risk of meningococcal disease.)**

Quadrivalent polysaccharide vaccine

Name \_\_\_\_\_  
 Last First M.I.

**G. Tuberculosis Screening** (PPD required regardless of prior BCG inoculation.)

1. PPD (Mantoux) within the past 12 months (tine or monovac not acceptable) Date Given:   
 Result: Neg \_\_\_\_ Positive \_\_\_\_ mm induration (horizontal diameter) \_\_\_\_\_ Date Read:   
 2. If PPD is positive, chest X-ray required: Result: Normal \_\_\_\_ Abnormal \_\_\_\_

**H. Other**

Hepatitis A (two doses, given at least 6 months apart, for those who travel to parts of the USA or other countries with high rates of Hepatitis A) #1  #2

Other Immunizations: \_\_\_\_\_  
 \_\_\_\_\_

**ATTENDING PHYSICIAN**

Name \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_  
 Address \_\_\_\_\_  
 Signature \_\_\_\_\_

**PART III - STATEMENT OF EXEMPTION TO IMMUNIZATION LAW**

IN THE EVENT OF AN OUTBREAK, EXEMPTED PERSONS WILL BE SUBJECT TO EXCLUSION FROM SCHOOL AND QUARANTINE.  
**MEDICAL EXEMPTION**

The physical condition of the above named person is such that immunization would endanger life or health, or is medically contraindicated due to other medical conditions. \_\_\_\_\_  
 \_\_\_\_\_

Signature of Physician

Date

**RELIGIOUS OR PERSONAL EXEMPTION (PLEASE SPECIFY BY CIRCLING ONE)**

Parent or guardian of the above named person or the person himself/herself adheres to a religious or personal belief opposed to immunizations.

Signature of Parent or Guardian or Emancipated Student/Consenting Minor Date

**THIS FORM COMPLIES WITH THE RECOMMENDATIONS OF THE AMERICAN COLLEGE HEALTH ASSOCIATION.**

**THE FOLLOWING AREA IS FOR COLGATE USE ONLY**

I have been provided a copy, and have read or have had explained to me, information about the diseases and the vaccine(s) listed below. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccines cited, and ask that the vaccine(s) listed below be given to me.

Vaccine	Date Given	Site	MFR & Lot #	VIS Date	Given By	Student Signature

Mantoux	Date Given	Site	MFR & Lot #	VIS Date	Given By	Student Signature	Date/Result