IMMUNIZATION REQUIREMENTS

New York State law and Farmingdale State College, in keeping with recommendations of the American College Health Association and the Centers for Disease Control, require all students born on or after January 1, 1997 who are attending an institution of higher education to show proof of two doses of live measles vaccine, one dose of live mumps vaccine and one dose of live rubella vaccine, given after one year of age. In lieu of immunization dates, the physician may provide a date of disease for measles and mumps only; history of rubella disease is not acceptable. Student may also choose to have blood tests called titers in lieu of immunizations which will show actual levels of immunity to each of the three diseases. If titers are drawn, please attach copies of actual laboratory reports.

Please use grid above to enter information. Please attach copies of laboratory reports for all titers.

Please use grid above to enter information. Please attach copies of laboratory reports for all titers.

ALL NURSING, DENTAL HYGIENE AND MEDICAL LABORATORY TECHNOLOGY STUDENTS MUST SUBMIT THE FOLLOWING TITERS, WHICH ARE REQUIRED FOR THEIR CLINICAL ROTATIONS:

- Hepatitis B (proof of shot)
- Measles
- Mumps
- Rubella
- Varicella

Please use grid above to enter information. Please attach copies of laboratory reports for all titers.
MEDICAL HISTORY

(Complete before going to your physician.)

Family History

<table>
<thead>
<tr>
<th></th>
<th>Age</th>
<th>State of Health</th>
<th>Age of Death</th>
<th>Cause of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td>___</td>
<td>___</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Mother</td>
<td>___</td>
<td>___</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Brother(s)</td>
<td>___</td>
<td>___</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Sister(s)</td>
<td>___</td>
<td>___</td>
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<td>___</td>
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<tr>
<td>Spouse/Partner</td>
<td>___</td>
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<tr>
<td>Children</td>
<td>___</td>
<td>___</td>
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</tr>
</tbody>
</table>

Check if any of your relatives have had any of the following. (Indicate relationship if checked)

- Alcoholism
- Asthma
- Arthritis
- Cancer
- Diabetes
- Epilepsy/Seizures
- Emotional Problem/Mental Illness

Personal History

Check if you have had any of the following. Comment on all check conditions in the space below.

- Alcoholism
- Allergy (Food)
- Allergy (Environment)
- Anemia
- Arthritis
- Back Problems
- Bronchitis/Pneumonia
- Cancer/Tumor/Cyst
- Chicken Pox
- Diabetes
- Ear Trouble/Hearing Loss
- Eating Disorder/Anorexia or Bulimia
- Emotional Distress/Problems
- Eye Problem
- Fungal Disease
- Gastrointestinal Disease
- Head Injury
- Heart Disease
- High Blood Pressure
- High/Low Blood Pressure
- Intestinal/Stomach Problems
- Joint Problems
- Kidney Disease/Infection/Stone
- Lyme Disease
- Menigitis
- Migraines/Headaches
- Mononucleosis
- No/Sinus Problem
- Rheumatic or Scarlet Fever
- Seizures/Epilepsy
- Sexually Transmitted Disease
- Shortness of Breath
- Skin Problem
- Sleep Disorder
- Surgery

Please list all DRUG ALLERGIES

- Have you consulted or been treated by a psychiatrist, clinical psychologist, social worker, or other counselor? □ Yes □ No
  If Yes, Please explain: ____________________________

- Are you taking any medications? □ Yes □ No
  If Yes, Please list: ____________________________

  If you have been hospitalized or have any medical problems, please explain: ____________________________

PHYSICAL EXAMINATION

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Blood Pressure</th>
<th>Pulse</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Skin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Eyes</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3. Ears</td>
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<td></td>
<td></td>
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<tr>
<td>4. Nose/Sinuses</td>
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<td></td>
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<tr>
<td>5. Mouth/Throat/Dental</td>
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<td></td>
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</tr>
<tr>
<td>6. Neck/Throat</td>
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<tr>
<td>7. Heart</td>
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<td></td>
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<tr>
<td>8. Lungs/Chest</td>
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<td></td>
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<tr>
<td>9. Breasts</td>
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<tr>
<td>10. Abdomen</td>
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<tr>
<td>11. Nervous System</td>
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<tr>
<td>12. Extremities/Joins</td>
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<tr>
<td>13. Back</td>
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<td></td>
<td></td>
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<tr>
<td>14. Gynecological System</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>15. Emotional/Mental Status</td>
<td></td>
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</tr>
</tbody>
</table>

LAB WORK

- Hemoglobin or Hematocrit (numerical value): ____________________________
- Date of Test: ____________________________
- Date of Reading: ____________________________
- Results in millimeters: ____________________________
- If mantoux is positive (>10mm): ____________________________
- If recent converter or chest x-ray positive, explain treatment: ____________________________

FOR STUDENTS WHO ARE PLANNING ON PARTICIPATING IN ATHLETICS

- Student is fully cleared to participate in athletics. □ Yes □ No
- EKG was done and is within normal limits. (ATTACH COPY)

Please comment on any abnormal condition the student has had or is being treated for: ____________________________

Recommendations for physical activity: □ Unlimited □ Limited (with explanation below)
- Recommendations regarding care of this student (with explanation below)
- Student now under treatment for medical or emotional condition (with explanation below)