Farmingdale State College

(631)420-2009/2014

HEALTH AND WELLNESS CENTER

STUDENT INFORMATION, MEDICAL HISTORY, AND PHYSICAL REPORT

(Complete pages 1 and 2 before going to your health care provider for physical examination.)

****COMMUTERS: Please go to www.farmingdale.edu, to read and electronically submit mandatory Meningitis Letter.**

The information requested on this form is for the use of the Health and Wellness Center and will not be released to anyone without your knowledge and consent except as required by law.

THIS FORM IS REQUIRED FOR ALL FULL-TIME STUDENTS

Date_____ **Student Name**_____
Last First M.I.

RAM Student Identification #_____

Home Address

_____
Number and Street Apt. #

_____
City State Zip

_____
Country

Sex

☐ Male ☐ Female ☐ Other

Date of Birth

____/____/____
Month Day Year

Cell Phone / Home Phone

_____
Area Codes and Numbers

Email Address:_____

Are you planning to reside on campus? ☐Yes ☐No

What is your major?_____ **Are you an athlete?** ☐Yes ☐ No

In Case of Emergency, Contact

_____
Name and relationship of person to be notified

_____
Number and street

_____
City State Zip

_____
Home telephone Business telephone

Alternative Emergency Contact

_____
Name and relationship of person to be notified

_____
Number and street

_____
City State Zip

_____
Home telephone Business telephone

Do you have medical insurance? ☐Yes ☐No

(If yes, please attach copy of insurance card.)

If you are interested in or have any questions regarding the College Insurance Plan, please contact the Insurance Claims Specialist at: (631) 420 - 2154

PARENTAL CONSENT FOR MEDICAL CARE OF STUDENTS UNDER 18 YEARS OF AGE

_____
Parent/Guardian Signature Relationship to student Date

_____
Notary Signature Date Notary Stamp

FOR DEPARTMENTAL USE Only

Pertinent Medical Information/allergies

_____

_____

****NOTE–* ALL RESIDENT STUDENTS *MUST* SUBMIT THIS COMPLETED FORM 30 DAYS PRIOR TO MOVING IN**

*** ALL NEW & TRANSFER ATHLETES MUST ALSO SUBMIT COPY OF EKG. SEE PAGE 3.**

MEDICAL HISTORY

(Complete before going to your physician.)

Family History:

	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brother(s)				
Sister(s)				
Spouse/Partner				
Children				

√ if any of your relatives has had any of the following	Indicate relationship (if checked)	√if any of your relatives has had any of the following	Indicate relationship (if checked)
Alcoholism		Gastrointestinal Disease	
Asthma		Heart Disease	
Bleeding Disorders		High Blood Pressure	
Cancer		Kidney Stones/Disease	
Diabetes		Mother took DES	
Epilepsy/Seizures		Rheumatoid Arthritis	
Emotional Problem/Mental Illness		Tuberculosis	

Personal History:

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

Alcoholism	Gallbladder Disease	Meningitis
Allergy(food)	Gum/Dental Disease	Migraines/Headaches
Allergy(Environmental)	Gynecological Problems	Mononucleosis
Anemia	Head Injury	Nose/Sinus Problem
Asthma	Heart Problems	Rheumatic or Scarlet Fever
Back Problems	Hepatitis/Jaundice	Seizures/Epilepsy
Bronchitis/Pneumonia	Herpes	Sexually Transmitted Disease
Cancer/Tumor/Cyst	Hernia	Shortness of Breath
Chicken Pox	High/Low Blood Pressure	Skin Problem
Diabetes	Insomnia	Speech Disorder
Ear Trouble/Hearing Loss	Intestinal/Stomach Problems	Surgery
Eating Disorder/Anorexia or Bulimia	Joint Problems	Thyroid Disease
Emotional Distress/Problems	Kidney Disease/Infection/Stones	Throat/Tonsil Problems
Eye Problem	Lyme Disease	Tuberculosis
Fungal Disease	Malaria	Urinary Tract Infection

Drug Allergies? Please List_____

- **Have you consulted or been treated by a psychiatrist, clinical psychologist, social worker, or other counselor? □Yes □No** _____
  Please explain.

- **Are you taking any medications? Please list.**_____

If you have been hospitalized or have any medical problems, give details:

PHYSICAL EXAMINATION

Height_____**Weight**_____**Blood Pressure**_____**Pulse**_____

1 Skin_____
2 Eyes_____
3 Ears_____
4 Nose/Sinuses_____
5 Mouth/throat/dental_____
6 Neck/thyroid_____
7 Heart_____
8 Lungs/chest_____
9 Breasts_____
10 Abdomen_____
11 Nervous system_____
12 Extremities/joints_____
13 Back_____
14 Genitourinary system_____
15 Emotional/mental status_____

DATE OF PHYSICAL EXAM_____

For females, date of LMP_____

Vision

Glasses □ Yes □ No

Contacts □ Yes □ No

Eye Glass Prescription_____

LAB WORK (required)

Hemoglobin or hematocrit _____
(numerical value)

Urine (required)
Albumin _____

Glucose _____

MANTOUX TEST FOR TB (within 1 year-required)

- **Date of test**_____
- **Date of reading**_____
- **Results in millimeters**_____

If mantoux is positive (>10mm):

- **Date of chest x-ray** _____
- **Results:** □ **Negative** □ **Positive**

If recent converter or chest x-ray positive, explain

- **Treatment:**_____

_____

Please list all allergies_____

Recommendations for physical activity: □ **Unlimited** □ **Limited (explain below)**

□ **Recommendations regarding care of this student (explain below)**

□ **Student now under treatment for medical or emotional condition (explain below)**

FOR STUDENTS WHO ARE PLANNING ON PARTICIPATING IN ATHLETICS:

□ **Student is fully cleared to participate in athletics.**

□ **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:

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, 1957 who are attending an institution of higher education to show proof of ***two doses of live measles*** vaccine and ***one dose of live mumps*** vaccine given after one year of age, **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***, which will show actual levels of immunity to each of the three diseases. If titers are drawn, student *must attach copies of actual laboratory reports to this record*. **(*Nursing, Dental Hygiene, and Medical Laboratory Technology students MUST have titers drawn. See below for further information.*)**

	DATE	DATE	DATE	DATE OF DISEASE	TITER DATE & RESULTS
	XXXXXX	XXXXXX	XXXXXX	XXXXXXXXXX	ATTACH ACTUAL LAB REPORT
MMR				XXXXXXXX	
MEASLES					
MUMPS					
RUBELLA				XXXXXXXX	
HEPATITIS-B				XXXXXXXX	
VARICELLA					
TETANUS-DIPHTHERIA				XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX
MENINGOCOCCAL				XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX

••ALL NURSING, DENTAL HYGIENE, AND MEDICAL LABORATORY TECHNOLOGY STUDENTS *MUST* HAVE THE FOLLOWING TITERS:

Measles
Mumps
Rubella
Hepatitis B (or proof of shots)
Varicella

•PLEASE USE GRID ABOVE TO ENTER INFORMATION.

•COPIES OF LABORATORY REPORTS FOR ALL TITERS MUST BE ATTACHED.

Provider's Signature_____
Print Name_____
Address_____
Phone _____ **FAX**_____
OFFICE STAMP:

Return this form to:
HEALTH AND WELLNESS CENTER
FARMINGDALE STATE COLLEGE
2350 BROADHOLLOW ROAD
FARMINGDALE, NY 11735