WALKER HEALTH CENTER
HEALTH HISTORY AND IMMUNIZATION FORM

Mary Walker Health Center, Bldg. #10
State University of New York at Oswego, Oswego, NY 13126
Fax# 315-312-5409 Phone# 315-312-4100 whealth@oswego.edu

Instructions and Information: Please provide the following information as completely as you are able. Information on this form is CONFIDENTIAL and is used for your health and safety while you are a student. Information will be released only with your written permission or with a court order. Call 315-312-4100 with questions. FAX number: 315-312-5409. E-mail whealth@oswego.edu

IDENTIFICATION:

Student ID# _____

Year Entering 20____ Fall _____ Spring _____

Student Status ❑ Freshman ❑ Transfer ❑ Graduate

_____
PRINT NAME

_____
ADDRESS

_____
CITY STATE ZIP CODE

Telephone Number: Home (_____) _____

Cell Phone Number: (_____) _____

Birth Date: Month/Day/Year _____

Gender: ❑ Decline to Answer ❑ Male ❑ Female
❑ Transgender male/Transman/FTM ❑ Transgender female/Transwoman/MTF
❑ Non-binary gender. *Please Specify*: _____
❑ Additional Category. *Please Specify*: _____

Race: *Please Specify*: _____

Country of Birth _____

Citizenship: US _____ OTHER (specify) _____

During the last five years, have you lived outside the US or your home country for a month or more? ❑ Yes ❑ No Where? _____

Mother's Name: _____

Father's Name: _____

PERSON TO NOTIFY IN CASE OF AN EMERGENCY:

_____
Name Relationship

_____
Address

( )
_____
Home Telephone Number

( )
_____
Business Telephone Number

YOUR LIFESTYLE: ARE YOU . . .

YES	NO	
❑	❑	A consistent seat belt user?
❑	❑	Tobacco user? Chewing _____ Smoking _____ How many years? ____ How many cigarettes per day? ____
❑	❑	Concerned about your weight?
❑	❑	An alcohol consumer? How many per day? _____ per week? _____
❑	❑	Performing testicular or breast self exam?

HEALTH: *Answer All Questions*

Describe any treatment you are currently receiving:

List any current medications:

YES	NO	
❑	❑	Are you ***allergic*** to medications? **List them:**
❑	❑	Are you ***allergic*** to foods? **List them:**
❑	❑	Latex allergy?

AUTHORIZATION: FOR ALL STUDENTS UNDER THE AGE OF 18

Signature of parent/guardian indicates SUNY Oswego Walker Health Center has permission to provide medical care or emergency treatment for your child. This includes care and treatment by other consultants, if deemed necessary.

_____
Signature of Parent / Guardian

_____
Daytime Phone Number Home Phone Number (if different)

HEALTH INSURANCE INFORMATION:

- **Must cover OUTPATIENT healthcare in this community.**
- **Student should have his/her own insurance card!**
- **Is pre-authorization required? ❑ Yes ❑ No**
  If "yes", phone # to call:

_____
Ins. Company Name

_____
Ins. Company Address

_____
City State Zip

_____
Insured's Name Relationship to patient

_____
Employer:

_____
Employer Address:

_____
Policy Number

_____
Plan Code Group Number

Is PRESCRIPTION COVERAGE included with this plan?
❑ Yes ❑ No if "Yes", Co-pay amount _____

PAST MEDICAL HISTORY:

Have you had any of the following problems?:

- ❑ Anemia
- ❑ Asthma
- ❑ Bladder/Kidney Infection
- ❑ Cancer or Malignancy
- ❑ Chicken Pox (date ___ /___/___)
- ❑ Chronic Inflammatory
- ❑ Concussion
- ❑ Bowel Disease
- ❑ Heart Problems
- ❑ Hepatitis
- ❑ Infectious Mononucleosis
- ❑ Knee Injury
- ❑ Mental Health Problems
- ❑ Obesity
- ❑ Phlebitis
- ❑ Polio
- ❑ Rheumatic Fever
- ❑ Thyroid Disease
- ❑ Tuberculosis
- ❑ Treatment to prevent Tuberculosis
- ❑ Sexually Transmitted Disease such as: Chlamydia, HIV, HPV,
- ❑ Vaginitis, i.e. Trichomonas, Monilia, or Bacterial Vaginosis

❑ Other _____

❑ Surgery _____

❑ I have read this section and none apply.

FAMILY MEDICAL HISTORY:

Please check below if any blood relatives have/had any of the diseases listed. Mother (M), Father (F), Siblings (S), Grandmother (GM), Grandfather (GF), Children (C)

YES	WHO	
_____	_____	Alcoholism
_____	_____	Allergy/Asthma
_____	_____	Bleeding Problems
_____	_____	Cancer _____
_____	_____	Diabetes
_____	_____	Epilepsy
_____	_____	Headache
_____	_____	Heart Disease
_____	_____	High Blood Pressure
_____	_____	Kidney Disease
_____	_____	Mental Problem
_____	_____	Nervous Problem
_____	_____	Obesity
_____	_____	Ulcer
_____	_____	Tuberculosis

IS THERE ANY OTHER INFORMATION ABOUT YOUR MEDICAL HISTORY OR CURRENT MEDICAL NEEDS WE SHOULD KNOW?

_____

_____

_____

WHO IS YOUR CURRENT HEALTH CARE PROVIDER?

Name (print): _____

Phone: _____

CURRENT MEDICAL STATUS:

Are you under treatment for or have you had any of the following with in the PAST YEAR?:

- ❑ Arthritis/Joint Problems
- ❑ Asthma
- ❑ Attention Deficit Disorder
- ❑ Bleeding/Blood Disorder
- ❑ Cancer _____
- ❑ Chronic Skin Condition or Eczema
- ❑ Concussion
- ❑ Diabetes
- ❑ Digestive Problems
- ❑ Disabling Condition
- ❑ Dizziness/Fainting
- ❑ Eating Disorders including binging
- ❑ Frequent Colds
- ❑ Hay Fever, Allergies
- ❑ Hearing Impairment
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Irritable Bowel Syndrome
- ❑ Kidney/Bladder Infection
- ❑ Mental Health Problems, Depression, Anxiety, Bipolar, OCD.
- ❑ Painful Menstruation
- ❑ Recurrent Diarrhea/Constipation
- ❑ Recurrent Headaches/Migraine
- ❑ Seizure Disorder (epilepsy)
- ❑ Visual Impairment

Explain: _____

_____

_____

❑ Other _____

❑ I have read this section and none apply.

OPTIONAL PHYSICAL EXAM:

*For students planning to participate in intercollegiate athletics,
See Mandatory Pre-participation Sports Physical Exam Form.

Blood Pressure _____ Height _____ Weight _____

PHYSICAL EXAM

Skin:

H.E.E.N.T.:

Neck:

Lymph Nodes:

Chest & Breasts:

Lungs:

Heart:

Abdomen:

Pelvic, Rectal, and Genitalia:

Skeletal & Extremities:

Neurological:

Please comment about student's physical and mental status including restrictions:

Signature: _____ MD/NP/PA

Print Name: _____

Address: _____

Phone: _____ Date: _____

State University of New York at Oswego • Immunization Form

Walker Health Center • 315-312-4100 ph • 315-312-5409 fax • whealth@oswego.edu

Name _____ Date of Birth _____ Student ID # _____

Have your doctor, nurse practitioner, physician's assistant or school nurse complete and sign the form
OR a copy of your immunizations from your high school, prior college, or private health care office is acceptable.

IMMUNIZATION RECORD REQUIRED* (Dates Must Be Written Mo/Day/Yr): Please read attach letter for detailed instructions.

DISEASE	Vaccine Date Given Mo/Day/Yr	Vaccine Manufacturer	Vaccine Lot Number	Initials of Vaccine Administrator OR certifying health professional	Physician Diagnosed Disease History (date onset)	Serology Date/Results (copy of lab report MUST be attached)
MEASLES*1	#1					
	#2					
MUMPS*2						
RUBELLA*3						
OR COMBINED MMR*1&2	#1	Merck				
	#2	Merck				
TETANUS/DIPHTHERIA Tetanus Diphtheria Tdap - Recommended						
VARICELLA Recommended	#1					
	#2					
HEPATITIS A	#1					
	#2					
HEPATITIS B Recommended	#1					
	#2					
	#3					
MENINGOCOCCAL MENINGITIS VACCINE Recommended: *OR* Menomune Menactra	#1					
GARDASIL Recommended	#1					
	#2					
	#3					

New York State Law requires all entering college students to have:

1 Two doses of LIVE virus measles (rubeola) vaccine (live vaccine was available after 1/1/68) at least 30 days apart.
The first dose of live virus vaccine administered after the age of 12 months.
A second dose administered more than 30 days after the first but after 15 months of age.

2 LIVE virus mumps vaccine (live vaccine was available after 1/1/68) administered after the age of 12 months.

3 LIVE virus rubella vaccine (live vaccine was available after 1/1/68) administered after the age of 12 months.

* **NOTE:** Students born before 1/1/57 do not need to fulfill measles, mumps, rubella requirement. Required for international students.

SIGNATURE REQUIRED:
I certify that the above immunization information is complete and accurate to the best of my knowledge:

Signature of provider or school official (MD, NP, PA, RN) Date

Print name and address of certifying provider or school official

Mantoux testing is required if foreign born in TB endemic country or travel to TB endemic country > 1 month.

TEST	CXR	Date placed Mo/Day/Yr	Manufacturer	Date Read	Size of Induration	Reader Initials
PPD						

OSWEGO
STATE UNIVERSITY OF NEW YORK

State University of New York at Oswego • Walker Health Center • Immunization Form

IMPORTANT INFORMATION TO HELP YOU FILL OUT THIS FORM CORRECTLY

- **Immunization and health history for student to fill out and return**
- **Optional Physical Exam**
- **Athletes: Mandatory Pre-participation Sports Physical Exam. See Additional Form.**

Walker Health Center and its professional staff welcome you to Oswego State. Pay attention to the following information to help you meet the health clearance requirements by correctly completing this Health History and Immunization Form. *Students who do not comply or fully meet this requirement will be restricted from class attendance.*

Where can you obtain an acceptable record of your immunizations?

- **High School** - These records must contain adequate information (the month, day, year) for each immunization.
- **Personal Immunization Records** - Transfer immunization information to this form and have your MD, NP, PA, or school nurse sign the form.
- **Local Health Departments** - If primary immunizations were received at your County Health Department request a certified copy from there.
- **Transfer Students** - Obtain a copy of your immunizations from your previously attended school by getting in direct contact with the Health Service.
- ***Meningococcal Meningitis vaccine*** - Recommended for students living in college residence halls. Meningococcal Meningitis is a rare, very serious, and potentially fatal disease. Certain strains of the disease can be prevented by vaccination. The vaccination has a lasting effect of up to 5 years. Talk to your health care provider about the need for this vaccine.
- ***Tdap*** - Recommended within 10 years.

For further information, please contact Walker Health Center at 315-312-4100 Monday through Friday 9 a.m. to 4 p.m.

INSTRUCTIONS:
Follow printed instructions for each section of this form and then mail, fax, or email it directly to Walker Health Center.
Complete the Personal Information and Health Insurance Information. Insurance information is necessary if you need outpatient laboratory or x-ray services as an adjunct to your care at Walker Health Center as well as for emergencies.

The Immunization Record is extremely important and complex.
You cannot live on campus or attend class if this information is incomplete or inaccurate, and/or a Certifying Signature is not included.

- Review the requirements carefully with your school nurse, health care provider, or clinic.
- Submit your immunizations with your clinician's signature (MD, NP, RN, or PA) OR an official copy from your high school or college is acceptable.
- Update vaccines as indicated by the stated standards.
- Exemptions are considered for medical or religious reasons only. All exemption requests must be in writing with all details of request included.
- Skin testing for tuberculosis exposure will be performed on campus at Walker Health Center for persons born or having residence in environments with endemic tuberculosis or students needing testing for community service or employment.

Health Insurance information - including this information will ease student access to referrals.
Before waiving the Oswego State Student Health Insurance Plan, be sure your current coverage can be used for* OUTPATIENT SERVICES *(lab costs, x-rays) and specialist referrals in this community.

Personal and Medical History

- Complete as accurately as possible with necessary explanations. Accuracy of information will allow our providers to provide safe health care. You have the option to complete the health history via online link in new student menu or completing the whole form and sending with your immunizations.

Permission to treat underage students

- Parents of students under 18 years of age must complete this section.

OPTIONAL PHYSICAL EXAM: Who should have a physical?

- Athletes: **Mandatory Pre-participation Sports Physical Exam. See Additional Form.**
- Any student with a history of chronic disease (asthma, diabetes, arthritis, cancer, heart, kidney, endocrine, lung disease, or any eating disorder).

Due Date:	As soon as possible. (ASAP) Students will NOT be able to register for orientatin until this form and your Health History Form are received. Health History form can be accessed from link on new student menu or www.oswego.edu/walker.
Return the form by mail, email or fax:	Walker Health Center, Bldg. #10 State University of New York at Oswego Oswego, NY 13126 whealth@oswego.edu Fax # (315) 312-5409