SYRACUSE UNIVERSITY
HEALTH SERVICES
111 Waverly Avenue
SYRACUSE NY 13244-2320
315/443-2666 fax: 315/443-9010

Please print in black or blue ink

You are responsible for returning these forms in their entirety to Health Services. **We suggest that you copy these forms for your records.**

PART 1: TO BE FILLED OUT BY THE STUDENT

Full Legal Name: ____ Date: _______________
Last (or family) First Middle (or maiden)

Date of Birth: _____________________ Age: ______ Sex: ______ Social Security Number: ___________________

Home Address:____
and Street City State Zip Code

____________________________ Telephone: _______/______________ Class at SU ______ Undergrad / Grad
Country Area Code (Circle One)

Marital Status: ___________________ Birthplace: __________________ Religion (optional): __________________

Personal Physician: ___________________ Address:____________________ Telephone: ______/_______________

Medical Insurance:____ Policy Number: _______________________

Address:_______________________ Telephone: ______/_______________ Subscriber: _______________________

Have you ever been a student at SU before? ________ If so, indicate when you graduated or separated:

Date of Graduation/Separation: ____________________ Name (if changed): ________________________________

Next of kin or person to be notified in case of emergency:

Name: ____ Relationship: ________________________

Address: ____ Telephone: _______/___________________

TO ALL STUDENTS, PARENTS, PHYSICIANS:
Please be candid on this form. This person will presumably be a resident of Syracuse for the next few years and anything less than full disclosure could be mutually disadvantageous. This is a highly confidential document for sole use by the professional staff at Syracuse University Health Services. NO INFORMATION ON IT MAY BE RELEASED TO ANYONE WITHOUT THE STUDENT'S WRITTEN CONSENT. If there are any questions, please contact the Director of Health Services.

MEDICAL CARE AUTHORIZATION:
“I, the undersigned, hereby specifically authorize Syracuse University Health Services and/or any authorized member of its staff, or duly affiliated consultant, to provide care in the Syracuse University Health Service and for emergency treatment, including mental health."

SIGNATURE OF STUDENT: If under 18 years of age signature of both parent/guardian and student is required.

STUDENT: ____ DATE: _________________

PARENT/GUARDIAN: ____ DATE: _________________

NOTE: WITHOUT THIS SIGNED AUTHORIZATION, HEALTH SERVICES CANNOT TREAT THIS STUDENT

If you have any physical and/or emotional disabilities that may require consideration in terms of mobility, class access, hearing or visual assistance, room assignment, etc., please describe them on page 3. This will in no way affect your current acceptance to Syracuse University but will allow us to plan in advance to assist you when you arrive on campus.

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

Note: If you answer "YES" to any of the following please explain in the space provided on the next page.

	YES
ALLERGIES TO:	
Medication	
Food	
Environment	
CUTANEOUS (SKIN)	
Acne	
Eczema/allergic skin disease	
Psoriasis	
Ophthalmic problems (include glasses/contacts)	
RESPIRATORY	
Asthma	
Bronchitis	
Hay Fever	
Pneumonia	
Ruptured/perforated eardrum	
CARDIOVASCULAR (HEART)	
Heart murmurs (specify if possible)	
Heart pounding/skipping	
High/low blood pressure	
Phlebitis	
Rheumatic Fever	
Have you ever had your cholesterol checked? Result (if known)	
GASTROINTESTINAL	
Abdominal pain (severe/recurrent)	
Blood in the stool	
Diarrhea (chronic/recurrent)	
Hepatitis	
Hernia	
Parasitic infection	
Ulcer	
Ulcerative colitis/Crohn's Disease	
GENITOURINARY	
Amenorrhea (no periods)	
Blood/protein in urine	
Cystitis (bladder infection)	
Dysmenorrhea (painful periods)	
HPV (genital warts)	
Nephritis or other kidney disease	
Pregnancy	
In her pregnancy which resulted in your birth, did your mother receive any DES (diethylstilbestrol)?	
MUSCULOSKELETAL	
Back problems	
Fractures/joint disability	
Severe sprains, ligament injury	
METABOLIC/ENDOCRINE/NUTRITION	
Diabetes	
Thyroid disorder (specify)	
Eating disorder (anorexia, bulimia)	

	YES
HEMATOLOGIC	
Anemia	
Mononucleosis	
NEUROLOGIC/PSYCHIATRIC	
Dizzy or fainting spells	
Frequent or severe headaches	
Seizures	
Severe head injury	
Depression	
Psychosis	
Psychotherapy	
INFECTIOUS DISEASES	
Tuberculosis	
STD (sexually transmitted disease)	
Rubella (German measles)	
Whooping cough (pertussis)	
PAST MEDICAL HISTORY	
Have you ever been hospitalized or had any operations?	
Do you have any major medical problems?	
Do you take any medications? (include vitamins and birth control pills)	
Do you receive allergy shots?	
Is there a family history of any major medical problems (allergies, cancer, diabetes, heart disease, high blood pressure, mental illness, tuberculosis, or hereditary disease)?	
Is there any other information you would like us to know about your health?	

FAMILY HISTORY

RELATION	AGE	STATE OF HEALTH	AGE AT DEATH	CAUSE OF DEATH
Father				
Mother				
Brothers				
Sisters				
Children				

PLEASE USE THIS SPACE TO ELABORATE THE COURSE AND OUTCOME OF ALL SITUATIONS IDENTIFIED IN THE "YES" COLUMN ON PAGE 18.

All of the information on this form is accurate to the best of my knowledge.

STUDENT SIGNATURE: ____ DATE:____________________

PART 2: MUST BE COMPLETED AND SIGNED BY A HEALTH CARE PRACTITIONER.

To the practitioner: a physical examination and/or assessment of the physical status of this student from previous examinations and knowledge of the individual is needed for registration at Syracuse University. Please fill out completely.

Ht. __________ Wt. __________ BP __________ Visual Acuity <u>Uncorrected</u> L 20/ R 20/ <u>Corrected</u> L 20/ R 20/

	Normal	Abnormal	Please comment on all abnormal
H.E.E.N.T.			
Lungs and Chest			
Heart (including murmurs)			
Abdomen			
Extremities/Feet			
Musculoskeletal			
Skin			
Lymph nodes			
Neurologic			

HEALTH CARE PRACTITIONER'S SIGNATURE: ______________________________________ DATE:__________

PART 3: TO BE COMPLETED AND SIGNED BY A HEALTH CARE PRACTITIONER**.**

Syracuse University policy in accordance with New York State public health law requires all students to provide:

- Proof of immunity to measles, mumps, and rubella:
  - Dates of two doses of measles vaccine, or positive titer results, or physician documentation of disease and:
  - Date of one dose of rubella vaccine, or positive titer result and;
  - Date of one dose of mumps vaccine, or positive titer result, or physician documentation of disease.

  Note: persons born before January 1, 1957 are exempt from the measles, mumps, and rubella requirement.
- A completed response related to meningococcal meningitis vaccine indicating that the student has either been immunized within the preceding ten years or has opted not to obtain immunization against meningococcal disease.

Please list exact dates (month, day, year) for all immunizations:

Immunization Dates

MMR 1st injection: _____/_____/_____
MMR 2nd injection: _____/_____/_____

Measles 1st injection: _____/_____/_____
Measles 2nd injection: _____/_____/_____

Rubella injection: _____/_____/_____

Mumps injection: _____/_____/_____

Meningitis

Those students wishing to reduce their risk of meningococcal disease should consider receiving the meningitis vaccine. The vaccine is available at the S.U. Health Service, as is information about the disease and the benefits of the vaccine.

I have elected the following option:
_______ Have been immunized within the preceding ten years
Date of immunization: _____/_____/_____
_______ Not to obtain meningitis vaccine.

Signature of student: ________________________ Date: _________

Serologic Evidence Dates

	Date	**Result** (+ or -)
Measles titer:	_____/_____/_____	_____
Rubella titer:	_____/_____/_____	_____
Mumps titer:	_____/_____/_____	_____

Disease Dates

Measles: _____/_____/_____
Mumps: _____/_____/_____

Tuberculin Information

NOTE: To avoid possible unnecessary procedures and undue financial burden, tuberculosis screening for all international students will be done at S.U. Health Services prior to registration for classes.

PPD placed date: _____/_____/_____
PPD read date: _____/_____/_____
PPD result: _____mm x _____mm
Chest x-ray date: _____/_____/_____
Chest x-ray result: __________

Hepatitis B (optional)

The American College Health Association in conjunction with the Advisory Committee on Immunization Practices recommends that all college students receive Hepatitis B vaccine.

HepB 1st injection: _____/_____/_____
HepB 2nd injection: _____/_____/_____
HepB 3rd injection: _____/_____/_____

or Hepatitis B_s Antibody: _____/_____/_____

Other Immunization Dates

Tetanus: _____/_____/_____

Polio Completed: _____/_____/_____

HepA 1st injection: _____/_____/_____
HepA 2nd injection: _____/_____/_____

Varicella 1st injection: _____/_____/_____
Varicella 2nd injection: _____/_____/_____
Varicella Titer: _____/_____/_____ Result: _______
Varicella Disease: _____/_____/_____

I hereby attest to the accuracy of the information given:

HEALTH CARE PRACTITIONER'S SIGNATURE: ______________________________ DATE: ______________________

ADDRESS: ____ PHONE: ____________________