Mock Medical Form

This form must be submitted by July 1st for the Fall semester and January 1st for the Spring Semester
A $25 non-refundable fee will be applied to your fee bill if you are not compliant with your immunizations by the 10th day of class

Last Name	First Name	
Date of Birth	Sex: Male Female	Student ID #

Required By the State of New York and Young College
Two doses for each: Measles, Mumps, Rubella

Required Vaccination	Date Given	Required Vaccination	Date Given
MMR #1 (Measles, Mumps, Rubella)		MMR #2 (Measles, Mumps, Rubella)	

The following vaccines are recommended for college students:

Additional Vaccines Recommended	Date Given	Additional Vaccines Recommended	Date Given
DTP/DTaP/Tdap		Varicella (Chickenpox)	
Td (Tetanus-Diphtheria)		Meningococcal	
OPV/IPV (Polio)		HPV (Human Papillomavirus)	
Hep B (Hepatitis B)		Other:	
Hep A (Hepatitis A)		Other:	

Clinician Signature
[Signature required to validate the immunization information} **Date:**

Personal Physician/Healthcare Provider **Name:**	**Address**	
Telephone # **Fax #**	**City**	**State** **Zip**

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Personal Medical History -- Please circle all that apply

ADHD		High Blood Pressure
Alcohol/Drug use	Diabetes	HIV/AIDS
Anxiety/Depression	Eating Disorder	Mental Health
Asthma	Gastrointestinal	Migraine
Cancer	GYN	Mononucleosis
Cardiac Condition/heart murmur	Hepatitis B or C	Musculoskeletal
Coagulation	Seizures	Others - please explain

Do you have any allergies? Yes No ***If yes please explain:***

Prior Hospitalizations, Surgeries or Orthopedic Procedures -- Please list dates and reasons

Medications -- Frequent or regular please list all prescriptions, natural, and over the counter medications

Consent for Treatment: I hereby grant permission for Young College Health Services Staff to provide me with appropriate medical and mental health treatment including medications for treatment of illnesses/injuries and to arrange for any emergency medical care if circumstances at the time make it impossible for me to make such decisions. Furthermore, I understand the Student Health Services staff may disclose my student medical records and/or information from such records to appropriate College personnel in the event of a health or safety situation as determined by the Student Health Services Staff.

Student Signature_____ **Parent/Guardian Signature**_____ **Date**_____

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