Information you provide will not be used to influence your situation at this University; it will be used, if necessary, solely as an aid to providing necessary health care while you are a student. This information is strictly for the use of the Health Services, and will not be released to anyone without your knowledge and consent.

PLEASE RETURN BY AUGUST 1ST by postal mail or as an email attachment to StudentHealth@colgate.edu

COLGATE UNIVERSITY HEALTH SERVICES, 13 Oak Drive, Hamilton, NY 13346 315/228-7750

TO INCOMING STUDENTS: REPORT OF MEDICAL HISTORY (please print)

Last Name First Name Middle Name Cell Phone #

Address City State Country (If not U.S.A.) Zip + 4

Gender _____ Date of Birth (Month / Day / Year) _____/_____/_____ Colgate Class Year _____

Mother: Name Home Address Home Phone Cell Phone #

Business Address Business Phone

Father: Name Home Address Home Phone Cell Phone #

Business Address Business Phone

SPECIAL NEEDS

Do you believe that you have any special needs that the University should consider, in order to provide assistance with living and learning conditions?

□ Hearing □ Allergies □ Motor Deficits □ Dietary □ Vision □ Learning □ Speech □ Psychological □ Other

Describe: _____

Lynn Waldman, Director of Disability Services, is available to discuss your concerns. Phone 315/228-7375 or e-mail **lwaldman@colgate.edu**.

Do you currently get allergy shots? If yes, please specify: _____

I certify that, to the best of my knowledge, this information is correct. CONSENT FOR TREATMENT: The staff of the Colgate University Student Health Service has my permission for care and treatment. This may additionally include care and treatment by any hospital, surgeon, physician, or radiologist deemed necessary for appropriate medical, psychiatric, and/or surgical treatment. *If under 18, parent/guardian must sign*.

_____

Student's Signature (parent/guardian if under 18) ***Date***

SIGN HERE

TO THE EXAMINING HEALTH CARE PROVIDER: Please review the student's history and complete this form. Please comment on all positive answers.

THIS STUDENT HAS BEEN ACCEPTED. The information supplied will not affect the student's status: it will be used only as a background for providing health care. This information is strictly for the use of the Health Services and will not be released without student consent.

Name: _____ DOB:_____ was examined on this date: _____

Physical Exam was Normal: ☐ Y ☐ N Comments: _____

_____

Physical activity: ☐ Unlimited ☐ Limited (explain): _____

HT: _____ inches **WT:** _____ lbs **BP:** _____/_____ **BMI:** _____ **VISION: Right Eye:** 20/ **Left Eye:** 20/ **Corrected:**

RECENT LAB RESULTS: **ALLERGIES:** **CURRENT MEDICATIONS:**

Please note any health problem, chronic health condition or disability that may affect behavior or health at school:

Health care provider (M.D., D.O., P.A., N.P., R.N., school health professional, health official) verifying the above must sign below.

SIGN HERE

Name (please print): _____

Signature: _____ **Title:** _____ **Date:** _____

Address: _____ **Phone:** _____ **Fax:** _____

COLGATE UNIVERSITY
Hamilton, NY 13346-1398

IMMUNIZATION RECORD

Immunity is required prior to registration. Please complete and return this form.

Student Health Service
315/228-7750

PART I — TO BE COMPLETED BY STUDENT (Please Print)

Name _____
Last First M.I.

Date of Birth (Month / Day / Year) ____/____/____ Colgate Class Year _____

New York State Public Health Law requires that all students born after December 31, 1956 be adequately immunized. ***You are legally required to provide this information and to get the necessary immunizations, or you will be DENIED enrollment.*** If you qualify for a medical or religious exemption, please **complete Part IV**.

Part II - Meningococcal Vaccine

As required by NYS Public Health Law, I have read or had explained to me, the information enclosed with this form about meningococcal disease.
After choosing one of the following, the student or parent/guardian (if student under age 18) **must sign below**.*

____ I have had meningococcal vaccine: Dose #1 Date: ___/___/___
(If more than 5 years since Dose #1 or if recommended by physician.) Dose #2 Date: ___/___/___

OR

____ I decline to receive the vaccine at this time and understand the risks.

Student or Parent/Guardian (if student under age 18) Signature _____ **Date** _____ SIGN HERE

PART III — TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER, GIVE MONTH, DAY & YEAR.
If convenient, you may attach a ***signed*** copy of your immunization records, which must include all previous and recent shots.

A. M.M.R. (Measles, Mumps, Rubella) (Two doses required.)
1. Dose 1 given at age 12-15 months or later.
AND
2. Dose 2 given at age 4-6 years or later, and at least one month after first dose.

B. Tetanus-Diphtheria (Primary series with DtaP or DTP and booster in the last ten years meets requirement.)
1. Primary series of at least four doses with DtaP or DTP: #1 #2 #3 #4 #5
AND
2. Tetanus-Diphtheria (Td) booster within the last ten years
AND
3. Tetanus-Diphtheria-Acellular Pertussis (Tdap) booster (one dose as an adult)

C. Polio (Primary series in childhood meets requirement.)
1. IPV/OPV: #1 #2 #3 #4 IPV Booster (If recommended for travel.)

D. Varicella (Either a history of **chicken pox**, a positive Varicella antibody, or two doses of vaccine given at least one month apart, meets the requirement.)
1. History of Disease: No _____ **OR** Yes _____ (include date)
OR
2. Varicella antibody: Non-reactive _____ **OR** Reactive _____ (include date)
OR
3. Immunization: #1 #2 (given at least one month after first dose)

E. Hepatitis B (Three doses of vaccine or a positive Hepatitis surface antibody meets the requirement.)
1. Immunization: #1 #2 #3
OR
2. Hepatitis B surface antibody: Non-reactive _____ **OR** Reactive _____ (include date)

F. Quadrivalent Human Papillomavirus Vaccine (HPV) (Three doses of vaccine for males and females 11-26 years of age at 0, 2, and 6 month intervals.)
State month, day and year. #1 #2 #3

G. Hepatitis A (Two doses, given at least 6 months apart, for those who travel to parts of the USA or other countries with high rates of Hepatitis A.)
State month, day and year. #1 #2

H. Other Other Immunizations (such as Pneumococcal): _____

I. Tuberculosis Screening -- SEE SEPARATE FORM

Health care provider (M.D., D.O., P.A., N.P., R.N., school health professional, health official) verifying the above must sign below.
Name (please print): _____
Signature: _____ **Title:** _____ **Date:** _____
Address: _____ **Phone:** _____ **Fax:** _____ SIGN HERE

PART IV - STATEMENT OF EXEMPTION TO IMMUNIZATION LAW

IN THE EVENT OF AN OUTBREAK, EXEMPTED PERSONS WILL BE SUBJECT TO EXCLUSION FROM SCHOOL AND QUARANTINE.

MEDICAL EXEMPTION

The physical condition of the above named person is such that immunization would endanger life or health, or is medically contraindicated due to other medical conditions.

_____ _____
Signature of Physician Date

RELIGIOUS EXEMPTION

Parent or guardian of the above named person or the person himself/herself adheres to a religious belief opposed to immunizations.

_____ _____
Signature of Parent or Guardian or Emancipated Student/Consenting Minor Date