

SYRACUSE UNIVERSITY HEALTH SERVICES

111 WAVERLY AVENUE
SYRACUSE NY 13244-2320
315/443-2666 fax: 315/443-9010

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: _____ Sex: _____ Social Security Number: _____

Home Address: _____
& Street City State Zip Code Country

Home Telephone: _____/_____ Student Cell Phone: _____/_____
Area Code Area Code

Birthplace: _____

Personal Physician: _____ Address: _____

Telephone: _____/_____

Health Insurance: The University strongly recommends that students carry adequate health insurance coverage. It is important for you to understand what your plan does and does not cover and any limitations included. Always carry your insurance card(s) with you.

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

Name: _____ Relationship: _____

Address: _____ Telephone: _____/_____

TO ALL STUDENTS, PARENTS, AND HEALTH CARE PROVIDERS:

Health information submitted to Health Services via this form will be held confidential as part of the student's medical record in accordance with federal laws regarding confidentiality of protected health information. Health Services does exert the right to provide all or some of the information submitted via this form to the Syracuse University Counseling Center, at the discretion of the directors of Health Services and the Counseling Center.

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

PART 2: PLEASE COMPLETE THE FOLLOWING:

SIGNIFICANT MEDICAL PROBLEMS			
PAST SURGERIES			
MENTAL HEALTH			
ALLERGIES			
CURRENT MEDICATIONS			
Name	Strength	Dose	Frequency

STUDENT SIGNATURE: _____ DATE: _____

PART 3: A PHYSICAL EXAMINATION IS OPTIONAL: IF OBTAINING A PHYSICAL, YOUR HEALTH CARE PRACTITIONER MAY FILL OUT THE SPACE PROVIDED BELOW, OR ATTACH THEIR OWN FORM.

Ht. _____ Wt. _____ BP _____

Visual Acuity Uncorrected
L 20/ R 20/

Corrected
L 20/ R 20/

	Normal	Abnormal	Please comment on all abnormal
H.E.E.N.T.			
Lungs and Chest			
Cardiovascular (including murmurs)			
Abdomen			
Extremities			
Musculoskeletal			
Skin			
Lymph nodes			
Neurological			
Genitourinary			

OTHER:

HEALTH CARE PRACTITIONER'S SIGNATURE: _____ DATE: _____

PART 4: TO BE COMPLETED AND SIGNED BY A HEALTH CARE PRACTITIONER (or provide equivalent information on separate form).

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 *after one year of age*, **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.

- Proof of immunity to meningitis or 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 applicable immunizations:

THIS COLUMN IS REQUIRED

MEASLES/MUMPS/RUBELLA

(see above for options)

MMR 1st injection: ____/____/____

MMR 2nd injection: ____/____/____

Measles 1st injection: ____/____/____

Measles 2nd injection: ____/____/____

Mumps injection: ____/____/____

Rubella injection: ____/____/____

Serologic Evidence Dates:

Measles Titer: ____/____/____

Mumps Titer: ____/____/____

Rubella Titer: ____/____/____

Result

Pos Neg

Pos Neg

Pos Neg

Disease Dates

Measles: ____/____/____

Mumps: ____/____/____

Rubella: ____/____/____

MENINGITIS

Students wishing to reduce their risk of meningococcal disease should consider receiving meningitis vaccine. Vaccine is available at SU Health Services. Information about the disease and the vaccine is available at students.syr.edu/health.

Select Option 1 or Option 2 (select Option 2 even if you anticipate obtaining the vaccine at a later date):

Option 1 – I received a meningococcal meningitis vaccine on: ____/____/____ (must be within the preceding ten years)

Option 2 – To date, I have opted not to obtain meningitis vaccine (must sign):

Signature of Student: _____ Date: _____

Signature of Parent/Guardian if student is less than age 18: _____ Date: _____

THIS COLUMN IS OPTIONAL

TUBERCULOSIS SCREENING

If screening for tuberculosis has been performed recently, please provide the following information if available:

PPD placed date: ____/____/____

PPD read date: ____/____/____

PPD result: ____ mm x ____ mm

Chest X-ray date: ____/____/____

Chest X-ray result: _____

International students must have tuberculosis screening done at Syracuse University Health Services upon arrival on campus in accordance with guidelines from the American College Health Association even if prior screening has been performed.

OTHER IMMUNIZATIONS

Hep B 1st injection: ____/____/____

Hep B 2nd injection: ____/____/____

Hep B 3rd injection: ____/____/____

Hep A 1st injection: ____/____/____

Hep A 2nd injection: ____/____/____

Hep A+B 1st injection: ____/____/____

Hep A+B 2nd injection: ____/____/____

Hep A+B 3rd injection: ____/____/____

Tetanus Booster: ____/____/____

Polio: ____/____/____

Varicella 1st injection: ____/____/____

Varicella 2nd injection: ____/____/____

Varicella Titer: ____/____/____

Varicella Disease: ____/____/____

Result _____

I hereby attest to the accuracy of the information given:

HEALTH CARE PRACTITIONER'S SIGNATURE _____ DATE _____