MANDATORY

Herkimer College State University of New York
Health History/Physical Exam/Immunization Form

Semester Entering: _____

Name (please print): Last _____ First _____ MI _____

Date of Birth: _____ Gender: M ___ F ___ Other ___ Social Security or Student ID # : _____

Home Address | City | State | Zip Code

Student's College Address (Dorm or Apt.) | City | State | Zip Code

Student's Phone Number (cell): _____ Home Phone/Landline Number: _____

Emergency Contact Name: _____ Relationship: _____

Home Phone/Landline Number: _____ Work Phone: _____ Cell Phone: _____

PART I: IMMUNIZATION/MENINGITIS REQUIREMENTS:

New York State Public Health Law 2165 requires that ALL students attending college, taking 6 or more credit hours who were born ON or AFTER January 1, 1957, provide proof of immunity to measles, mumps and rubella. A copy of an official record (such as a high school record or military record) may be submitted in lieu of completing this section.

Measles Mumps & Rubella: Must be given after 01/01/1969 and ON or AFTER the first birthday. Doses must be at least 28 days apart.

MMR:

1st ____/____/____ (Mo Day Yr) 2nd ____/____/____ (Mo Day Yr)

OR

Measles (Rubeola) 2 doses:

1st ____/____/____ (Mo Day Yr) 2nd ____/____/____ (Mo Day Yr)

Rubella 1st ____/____/____ (Mo Day Yr) **Mumps** ____/____/____ (Mo Day Yr)

A titer proving immunity for each of the above is an acceptable alternative to receiving the immunizations. A copy of the result is required. Please attach to this form.

OTHER VACCINATIONS RECEIVED:

HEPATITIS B VACCINE:
Dose #1 _____ Dose #2 _____ Dose #3 _____

HEPATITIS A VACCINE:
Dose #1 _____ Dose#2 _____

VARICELLA:
Dose #1 _____ Dose#2 _____

HPV (GARDASIL):
Dose #1 _____ Dose #2 _____ Dose #3 _____

TD BOOSTER OR TDAP: (CIRCLE WHICH) DATE: _____

Tb Mantoux: Required ONLY for International students and students enrolled in the Physical Therapist Ass't., Childhood Education or Early Childhood Education Programs.

Date: _____ Result (in mm) _____ Chest x-ray if positive Date: _____ Result: _____

Health Care Provider (RN, LPN, NP, PA, MD/DO) Signature (Required)

Name: _____ Signature: _____ Date: _____

Address: _____ Phone Number: _____

PLEASE INCLUDE A COPY OF YOUR INSURANCE CARD (FRONT AND BACK)

MENINGITIS RESPONSE FORM: New York State requires that all students attending college and taking 6 or more credit hours complete the following (check one box and sign):

I have (for students under the age of 18: My child has):

☐ had meningococcal meningitis immunization within the past 5 years. Date received: _____

☐ read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I (my child) will NOT obtain immunization against meningococcal meningitis disease.

REQUIRED: Student's Signature _____ Date: _____

CONTINUED ON OTHER SIDE

PART II: PERSONAL HISTORY: Have you had or are you now under treatment for any of the following problems? (Check the box if yes and provide a brief explanation in the space below.)

□ Alcohol/Substance Abuse	□ Disabling Condition	□ Kidney Disease
□ Asthma	□ Eating Disorder	□ Orthopedic Problems
□ Back Trouble	□ Emotional Problems	□ Sickle Cell Disease
□ Blood Disorder	□ Epilepsy/Seizure Disorder	□ Splenectomy
□ Chicken Pox	□ Head injury/Concussion	□ Thyroid Disease
□ Congenital or other heart problems	□ High Blood Pressure	□ Tuberculosis or TB Contact
□ Diabetes	□ Intestinal Disease	□ Other

Explanation of above: _____

_____

Operations, severe injuries (include dates): _____

_____

Medications taken at present? Yes □ No □ (If Yes, please list): _____

_____

Allergies? Yes □ No □ (If Yes, please list): _____

Family History (List all familial diseases: diabetes, tuberculosis, mental illness, other): _____

_____

*****STOP HERE UNLESS A PHYSICAL IS REQUIRED*****

PART III: PHYSICAL EXAM:

REQUIRED for athletes & students in the Physical Therapist Assistant program or the Pre-Employment Police Academy. (Optional for all other students.)

NAME: _____ DOB: _____ DATE OF EXAM: _____ AGE: _____

GENDER: _____ B/P: _____ WEIGHT: _____ HEIGHT: _____

VISION FAR: R: 20/_____ L: 20/_____ □ without correction □ with correction

PHYSICAL EXAM	NORMAL	ABNORMAL	COMMENTS
1. General Appearance			
2. Skin			
3. HEENT			
4. Neck			
5. Lungs			
6. Heart			
7. Abdomen			
8. Musculoskeletal			
9. Psychiatric			

Is this student able to participate in all physical activity including intercollegiate sports? Yes _____ No _____

Is this student able to participate in strenuous and ongoing physical fitness training and testing throughout the Police Academy program? Yes _____ No _____

If No, what activities are to be eliminated? _____

Examining Health Care Provider (MD, DO, NP, PA): _____ Date: _____

Address: _____ Phone: _____

RETURN FORM TO: Herkimer College State University of New York
Dean of Students Office
100 Reservoir Road
Herkimer, NY 13350
315.866.1808 FAX or email DeanofStudents@herkimer.edu
Questions? Call 315.574-4009

(Revised 05/23/19)