Villa Maria College of Buffalo, 240 Pine Ridge Road, Buffalo, NY 14225
(716) 961-1866, Fax (716) 896-0705

MEDICAL HISTORY

PLEASE COMPLETE BEFORE YOUR PHYSICAL EXAMINATION (PLEASE PRINT):

NAME (LAST, FIRST, MIDDLE) _____

ADDRESS _____

TELEPHONE # _____ SOCIAL SECURITY # _____ DATE OF BIRTH _____

FAMILY MEMBER TO NOTIFY IN EMERGENCY: NAME _____ TELEPHONE # _____	PERSONAL PHYSICIAN OR CLINIC: NAME _____ TELEPHONE # _____
PERSON OUTSIDE FAMILY TO NOTIFY IN EMERGENCY: NAME _____ TELEPHONE # _____	HEALTH INSURANCE: _____ POLICY CERT/GROUP #: _____

MARK AN "X" IF YOU HAVE HAD OR HAVE BEEN TREATED FOR THE FOLLOWING:

- ❑ ALCOHOL DEPENDENCE OR OTHER PROBLEMS
- ❑ ANEMIA
- ❑ ARTHRITIS
- ❑ ASTHMA
- ❑ BRONCHITIS
- ❑ CANCER
- ❑ CEREBRAL PALSY
- ❑ CHICKEN POX
- ❑ CHRONIC INTESTINAL PROBLEMS
- ❑ DEPRESSION
- ❑ DIABETES
- ❑ DRUG DEPENDENCE
- ❑ EATING DISORDERS
- ❑ ECZEMA
- ❑ EPILEPSY
- ❑ EMOTIONAL PROBLEMS
- ❑ FREQUENT COLDS
- ❑ GERMAN MEASLES
- ❑ HAY FEVER
- ❑ HEPATITIS
- ❑ HEARING PROBLEMS
- ❑ HEART PROBLEMS (CONGENITAL OR OTHER)
- ❑ HIVES
- ❑ INFECTIOUS MONONUCLEOSIS
- ❑ KIDNEY DISEASE
- ❑ MALARIA
- ❑ MEASLES
- ❑ MULTIPLE SCLEROSIS
- ❑ MUMPS
- ❑ OPERATIONS—SURGERY (EXPLAIN BELOW*)
- ❑ ORTHOPEDIC PROBLEMS
- ❑ PNEUMONIA
- ❑ POLIO
- ❑ SCARLET FEVER
- ❑ SINUSITIS
- ❑ SPEECH DEFECTS
- ❑ TONSILLITIS
- ❑ TUBERCULOSIS OR TB CONTACT
- ❑ TYPHOID FEVER
- ❑ VISION PROBLEMS OTHER THAN CORRECTIVE LENSES
- ❑ WHOOPING COUGH
- ❑ RHEUMATOID HEART DISEASE

*SURGERY EXPLANATION _____

LIST ALLERGIES (FOOD, DRUG, ETC.) _____

LIST MEDICATIONS TAKEN REGULARLY _____

LIST COMMON FAMILY DISEASES (CANCER, HEART, ETC.) _____

LIST ANY PERMANENT PHYSICAL DISABILITY _____

REMARKS OR OTHER COMMENTS _____

STUDENT'S SIGNATURE _____ DATE _____

PHYSICIAN'S SIGNATURE _____ DATE _____
(ACKNOWLEDGING REVIEW)

(Confidentiality is kept in compliance with the Privacy Act of 1988.) (4/15)

PHYSICAL AND IMMUNIZATION RECORD FOR VILLA MARIA COLLEGE OF BUFFALO

TO THE EXAMINING PHYSICIAN: Review the student's medical history and complete the physical section and immunization record on this side of form. This student has been accepted. The information will not affect his/her status—it will be used only as a background for providing health care if necessary. This information is strictly for the use of Health Services and will not be released without student consent.

PART I—PHYSICAL

STUDENT'S NAME _____ DATE OF BIRTH _____

WEIGHT _____ HEIGHT _____ BLOOD PRESSURE _____ PULSE _____ TEMPERATURE _____

CLINICAL EVALUATIONS: Are there any abnormalities of the following? Describe fully. (Use reverse side if necessary.)

	Yes	No			Yes	No	
Head, Neck, Face, Scalp	❑	❑	_____	Abdomen	❑	❑	_____
Nose, Sinuses	❑	❑	_____	Endocrine	❑	❑	_____
Mouth, Throat	❑	❑	_____	Extremities	❑	❑	_____
Teeth, Gingiva	❑	❑	_____	Skin	❑	❑	_____
Eyes	❑	❑	_____	Neurological	❑	❑	_____
Ears	❑	❑	_____	Genitalia	❑	❑	_____
Lungs, Chest	❑	❑	_____	Spine, Musculo-Skeletal	❑	❑	_____
Heart	❑	❑	_____				

Describe any limitation of physical activity: _____

Considering the history and physical exam, in your opinion is this student able to meet the demands of college life? o YES o NO

Do you recommend further investigation or treatment? _____

PART II—IMMUNIZATION RECORD

A. M.M.R. (Measles, Mumps, Rubella) (Two doses required.)

1. Dose 1 given at age 12-15 months or later #1 ___/___/___ (M D Y)
2. Dose 2 given at age 4-6 years or later, and at least one month after first dose #2 ___/___/___ (M D Y)

B. TETANUS-DIPHTHERIA (Primary series with DtaP or DTP and booster with Td in the last ten years meets requirement. Refer to ACIP for details.)

1. Primary series of four doses with DTaP or DTP:

#1 ___/___/___ (M D Y) #2 ___/___/___ (M D Y) #3 ___/___/___ (M D Y) #4 ___/___/___ (M D Y)

2. Tetanus-Diphtheria (Td) booster within the last ten years ___/___/___ (M D Y)

C. HEPATITIS B (Three doses of vaccine or two doses of adult vaccine in adolescents 11-15 years of age, or a positive Hepatitis B surface antibody meets the requirement).

1. Immunization (Hepatitis B)

Dose #1 ___/___/___ (M D Y) Dose #2 ___/___/___ (M D Y) Dose #3 ___/___/___ (M D Y)

2. Immunization (Combined Hepatitis A and B Vaccine)

Dose #1 ___/___/___ (M D Y) Dose #2 ___/___/___ (M D Y) Dose #3 ___/___/___ (M D Y)

3. Hepatitis B Surface Antibody Date ___/___/___ (M D Y) Result: Reactive _____ Non-reactive _____

D. TUBERCULIN SKIN TEST ***(TB must be within the last six months.)***

Tine or Patch: Negative _____ Positive _____ Degree of Induration _____ Date: _____

SIGNATURE OF PHYSICIAN: _____ DATE: _____

PLEASE PRINT PHYSICIAN'S NAME, ADDRESS, AND TELEPHONE NUMBER: _____

_____

_____

PART III—MENINGOCOCCAL MENINGITIS IMMUNIZATION

TO BE COMPLETED AND SIGNED BY STUDENT OR PARENT/GUARDIAN FOR STUDENT UNDER THE AGE OF 18:

MENINGOCOCCAL (One dose within 10 years recommended by NYS PHL § 2167.)
CHECK ONE (1) BOX ONLY.

- ❑ Quadrivalent polysaccharide vaccine (Menomune™) ___/___/____ (M D Y) ___/___/____ (M D Y)
- ❑ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I (my child) will obtain immunization against meningococcal meningitis **within 30 days** of the beginning of the next semester.
- ❑ I have 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.

Signed _____ Date _____

PART IV—RELEASE STATEMENTS

TO BE COMPLETED AND SIGNED BY STUDENT OR PARENT/GUARDIAN FOR STUDENT UNDER THE AGE OF 18:

1. PERSONAL RESPONSIBILITY

I do not hold the College responsible for any adverse effects upon me (my child) that may result from regular college life or from participation in courses of study in which laboratory and/or studio work is required.

Signed _____ Date _____

2. AUTHORIZATION FOR HEALTH SERVICES

In the event of an emergency or the need for first aid, I hereby authorize the Villa Maria College Health Services Office to provide or procure appropriate care for me (my child).

Signed _____ Date _____

3 RELEASE OF INFORMATION

Is there any health concern indicated or not indicated thus far on these records which you feel should be taken into account when considering your (your child's) ability to pursue your (your child's) course of study or that will affect your (your child's) life on campus in general?

❑ YES ❑ NO If yes, please indicate: _____

In order to provide better health services and guidance, I hereby give my permission to the Manager of Health Records to inform appropriate instructors and/or other College personnel and/or agencies associated with completion of courses of study at the College of medical problems which may appear on these records.

Signed _____ Date _____

SEND COMPLETED FORM TO: Director of Student Success
Villa Maria College
240 Pine Ridge Road
Buffalo, New York 14225

OR FAX COMPLETED FORM TO: (716) 896-0705