

## COMPLETE HEALTH HISTORY AND PHYSICAL EXAMINATION FORM

PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS.

# THIS FORM MUST BE COMPLETED AND SUBMITTED TO THE HEALTH SERVICES CENTER PRIOR TO THE FIRST DAY OF CLASSES.

#### REQUIRED IMMUNIZATIONS

New York State Public Health Law 2165 requires that students enrolled for at least 6 credits and born on or after January 1, 1957, must submit proof of immunization to measles, mumps and rubella (German measles). New York State Public Health Law 2167 requires that students enrolled for at least 6 credits also complete the meningitis vaccination response form. To learn more about meningitis vaccination,

visit health.adelphi.edu/forms/meningitis.

The above requirements **must be submitted prior to the first day of classes.** Failure to comply will result in medical suspension from classes and subsequent withdrawal from the University. Students who require a medical or religious exemption must contact the Health Services Center at **516.877.6000** to discuss further requirements.

Family name/surname		First/given name		MI
Address				
AddressStreet	Apt.	City	State	Postal code
Adelphi ID no. or SSN	MANAGA AND AND AND AND AND AND AND AND AND AN	Date of birth		
Home phone ( )		- H I	No fine from the state of the s	
Email				
EMERGENCY CONTACT				
Name		Relationship		
Home phone ( )		Cell/work phone ( )		

Each student should have a copy of his or her insurance card at all times.

Health insurance is mandatory for all resident and international students. To learn about the requirements and waiver process, visit students.adelphi.edu/sa/hs/insurance.php.

sections are required to be completed.

#### CONSENT FOR MEDICAL TREATMENT OF MINORS (students under the age of 18):

To provide medical evaluation or treatment to students under the age of 18, parental permission is necessary by law. All students younger than 18 years old require a parent's or guardian's signature submitted to the Health Services Center for medical treatment consent.

I hereby grant permission for medical evaluation, treatment and hospitalization in case of accident or illness for my minor child/legal ward. I also give permission for the release of information concerning his or her medical condition to other responsible University officials when necessary, or to outside agencies for treatment on an as-needed basis.



#### **IMMUNIZATION RECORD**

Immunization records are required prior to the first day of class.

Please complete this form and return it to the Health Services Center or fax to **516.877.6008**. If any portion of this document is illegible, it will not be processed.

Healthcare provider's stamp or license number is required or it will NOT be processed.

	Family name/surname	First/given name	MI
Date of birth	Age	Adelphi ID no	o. or SSN
То сотр	oly with New York state immunization law, you m vaccine, at least one mumps and one rubella,	ust have some combination equivaler , or provide serological evidence of in	nt to two doses of measles nmunity (titers).
REQUIRED IMMUNIZ	ATIONS (to be completed by a healthcare pro	vider)	
MMR (measles, mumps	rubella)—If given as a combined dose instead (	of individual immunizations	
☐ Dose 1: Immunized no more than four days prior to first birthday and after 1971			Date / /
Dose 2: Immunized as	s above and at least 28 days after first dose of M	IMR	Date/
Or		***************************************	
MEASLES—Two doses a	at least 28 days apart, given no more than four	days prior to first birthday and after 19	967
Dose 1: Immunized or			Date/
Dose 2: Immunized as	s above and at least 28 days after first dose of m	easles	Date/
MUMPS—One dose afte			Date / /
RUBELLA (German mea	sles)—One dose after January 1, 1968		Date/
Or			
Serologic evidence of it	mmunity for each disease—Laboratory reports	verifying immunity (IgG) to measles,	mumps and
rubella are required (tite Lab reports attached	is).		
RECOMMENDED IMM	UNIZATIONS		
Tdap (booster recomm	nended for all students) / /	Meningococcal Type B vaccine d	ate / /
		Meningococcal Type ACYW-135 c	late//
Or		(must also complete under Part D	))
Tetanus toxoid (withi	n 10 years)/		
Chicken pox (varicell	a) immunization 1)/ 2)/		
Hepatitis B series 1)	//2)/3)/	/	
Hepatitis A series 1)	/(if conside	ering or definitely traveling abroac	3)
Gardasil series 1)	_//	/	
Note: If student is a nu hepatitis B will be requ	rsing major, serological evidence of immu ired for clinical rotations.	nity (titers) to measles, mumps, ru	ubella, varicella and
	Official stamp is required; no form will be a	accepted without stamp, or licen	se number if no stamp available
	Ph		
2:8:10:010	Lic	ense no.	

\_\_\_ Stamp

	name/surname First/given name		MI
Adelphi ID no. or SSN		Date of birth	Age
SECTION 1 (Student must co			7,90
		•	or intolerance
Does student require EpiPen?	? ☐ Yes ☐ No Has stu	udent been trained in its use?  s and any over-the-counter med	l Yes □ No
Past medical history			
Family medical history			
Height Weight	BMI	ION (to be completed by provid Blood pressure	Heart rate
Vision RL	(corrected or uncorrected) Hearing (whisper ac		(whisper acceptable)
System	Satisfactory	Unsatisfactory	Details, if Unsatisfactory
HEENT			
Respiratory			
Cardiovascular			
Abdominal			
Genitourinary Genitourinary			
Genitourinary Musculoskeletal			
Abdominal Genitourinary Musculoskeletal Gkin Neurovascular			
Genitourinary Musculoskeletal Bkin Neurovascular Fuberculosis Testing: This is n or student teaching. For inter	national students or the	ose who may have received BC	entering into health-related clinical sites G vaccine, the T-Spot.TB (preferred) or
Genitourinary  Musculoskeletal  Skin  Neurovascular  Fuberculosis Testing: This is nor student teaching. For interplantiferon blood test is reconstruction.	national students or the quired. (A copy of the la	ose who may have received BC ob test is required.)	G vaccine, the T-Spot.TB (preferred) or
Genitourinary  Musculoskeletal  Skin  Neurovascular  Fuberculosis Testing: This is nor student teaching. For interiouantiFERON blood test is reconstructed.  ST (PPD): Date placed	national students or the quired. (A copy of the la	ose who may have received BC ob test is required.)	G vaccine, the T-Spot.TB (preferred) or  Result in mm (Must be written.):
Genitourinary  Musculoskeletal  Bkin  Neurovascular  Fuberculosis Testing: This is not student teaching. For interpluantiFERON blood test is reconstituted to the PPD positive or negative.  Stopot.TB or QuantiFERON results.	national students or the quired. (A copy of the la R or L forearm ( ? (Circle one.) If positive	cse who may have received BConb test is required.)  Circle one.) Date read  e, must have chest X-ray with Circle.	G vaccine, the T-Spot.TB (preferred) or  Result in mm (Must be written.):
Genitourinary  Musculoskeletal  Skin  Neurovascular  Fuberculosis Testing: This is not student teaching. For interpluantiFERON blood test is reconstituted by the PPD positive or negative sthe PPD positive or negative staperwork.)	national students or the quired. (A copy of the la R or L forearm (? (Circle one.) If positivalt: (If the	cse who may have received BConb test is required.)  Circle one.) Date read  e, must have chest X-ray with Circle.	G vaccine, the T-Spot.TB (preferred) or  Result in mm (Must be written.):  XR result attached. lab test must be included with this
Genitourinary  Musculoskeletal  Skin  Neurovascular  Fuberculosis Testing: This is not student teaching. For interpluantiFERON blood test is reconstituted by the PPD positive or negative sthe PPD positive or negative staperwork.)	national students or the quired. (A copy of the later of	cose who may have received BCost test is required.)  Circle one.) Date read  e, must have chest X-ray with Cost tests are done, a copy of the ve years and a copy of the X-ray	G vaccine, the T-Spot.TB (preferred) or  Result in mm (Must be written.):  XR result attached. lab test must be included with this
Genitourinary  Musculoskeletal  Skin  Neurovascular  Fuberculosis Testing: This is nor student teaching. For interiouantiFERON blood test is reconstructed to the PPD positive or negative sthe PPD positive or negative saperwork.)  Ill positive tests require a chesticular chesticular science of the PPS chapters and the second student is cleared for all physical positive tests require a chesticular science of the physical positive tests require a chesticular science of the physical positive tests require a chesticular science of the physical positive tests require a chesticular science of the physical physical positive tests require a chesticular science of the physical ph	national students or the quired. (A copy of the later of	cose who may have received BC ab test is required.)  Circle one.) Date read  e, must have chest X-ray with Cose tests are done, a copy of the ve years and a copy of the X-ray  chletic activities. Yes No	G vaccine, the T-Spot.TB (preferred) or  Result in mm (Must be written.):  XR result attached.  lab test must be included with this  results must be included.
Genitourinary  Musculoskeletal  Skin  Neurovascular  Fuberculosis Testing: This is nor student teaching. For interection of the placed of the PPD positive or negative as the PPD positive or negative apperwork.)  Ill positive tests require a chest tudent is cleared for all physical places appears to the place of the	R or L forearm ( ? (Circle one.) If positive ult: (If the st X-ray within the last fire ical activities and/or at	cose who may have received BC ab test is required.)  Circle one.) Date read  e, must have chest X-ray with Cose tests are done, a copy of the ve years and a copy of the X-ray  chletic activities. Yes No	G vaccine, the T-Spot.TB (preferred) or  Result in mm (Must be written.):  XR result attached.  lab test must be included with this  results must be included.

This form will not be accepted without date and healthcare provider's signature and stamp, or license number if no stamp available.



### MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE FORM

Family name/surname	First/given name	MI
Adelphi ID no. or SSN	Date of birth	
New York State Public Health Law 2167 r semester credits, or the equivalent per s University Health Services Center. For in vaccination, visi	emester, must complete and return the	following form to the Adelphi sease and the meningococcal
Please check one	e of the following boxes and sign	below:
I have/my child has (for students u	inder the age of 18):	
☐ Had the meningococcal mening Date received	itis immunization within the past five ye Healthcare provider stamp required _	ears.
	me, the information regarding meningo	
I understand the risks of not reconstrain immunization against me	eiving the vaccine. I have decided that I ningococcal meningitis disease.	/my child will not
Signature of student (if 18 or old	er/parent or guardian if student is a min	or) Date

This form must be returned to the Adelphi University Health Services Center, Waldo Hall, One South Avenue, P.O. Box 701, Garden City, NY 11530-0701, USA, or faxed to **516.877.6008**.

The form may be uploaded to the Health Portal in your eCampus account.

The above requirements must be submitted prior to the first day of classes. Failure to comply will result in medical suspension from classes and subsequent withdrawal from the University.