ROBERTS WESLEYAN COLLEGE

Health & Immunization Form for College Attendance/Sports Participation

Academic Year: 2 _____ ❑ Fall semester ❑ Spring semester ❑ Summer semester

❑ Undergraduate Freshman ❑ Transfer Student ❑ Remit Student
❑ International Student ❑ E.L.I. Student ❑ B.E.L.L. Student
❑ Athlete-Student Sport(s) _____

To secure confidentiality, please submit the completed form and documents directly to:

1. Mail to: Health Center
   Roberts Wesleyan College
   2301 Westside Drive, Rochester, NY 14624
2. Email at healthcenter@roberts.edu (at your discretion)
3. Fax (secured line) at 585-594-6920

Incomplete information or unsigned forms will not be processed.

Office Use Only

Received: _____

Recorded: _____

By Staff: _____

SUBMISSION DEADLINE

One month prior to first class session or sport participation.

Failure to comply with the New York State Public Health Law 2165 & 2167 regulations prevent clearance for attendance.

Last name: _____ First: _____ Middle Initial: _____

Date of birth: (MM-DD-YY) ____/____/____ Sex: M ❒ F ❒ Citizenship: U.S. ❒ Other ❒ (specify) _____

Address: (street/PO box) _____

City/Town: _____ State: ____ Zip: _____ Home Phone:(____)_____-_____

Cell Phone: (____) _____- _____ Email Address: _____

INSURANCE INFORMATION:

Last: (Primary) _____ First:_____ Middle Initial: _____
Relationship to student: _____ Primary's DOB: _____/_____/_____ Primary's Gender:_____
Insurance Company:_____
Policy No:_____ Group No:_____
Effective Date: _____/_____/_____ Termination Date: _____/_____/_____

RELEASE OF INFORMATION / EMERGENCY CONTACT:

I give permission to the Health Center staff at Roberts Wesleyan College to discuss my health care with the individual indicated below. I, also authorize this person to be called in case of an emergency.

Name: _____ Relationship: _____

Daytime phone #: _____ Evening Phone #: _____ Cell phone #: _____

Student's signature: (required) _____ Date: _____/_____/_____

AUTHORIZATION FOR TREATMENT

In submitting this Health and Immunization form, I attest the information is complete and accurate. I authorize Roberts Wesleyan College Health Center to provide medical treatment and services as they deem appropriate. I understand my information if pertinent may be shared to facilitate collaboration among the Athletic Department, Campus Security, Counseling Center or Learning Center staff to coordinate treatment for my comprehensive health care.

I understand that my medical records are confidential and maintained separately from my academic records. To have my medical records shared with others requires my written permission except in the event of a life-threatening and/or serious illness or injury of which the Health Center is aware, parents(s) or guardian may be notified at the discretion of the professional staff. *This authorization for treatment is active for the duration I am a student at Roberts Wesleyan College.*

Student's signature: (required) _____ Date: _____/_____/_____

Parent's signature: **(required if student is under age 18)** _____ Date: _____/_____/_____

General History: To be completed by the student and/or parent/guardian(s)

Please give details below for any "yes" answers

Have you had:	Y	N		Y	N		Y	N		Y	N
ADD/ADHD			Depression			Impaired Vision			Thyroid Disease		
Alcohol/Drug Dependency			Diabetes			Irritable/spastic bowel			Tuberculosis		
Anemia			Disease/Injury of Joints			Kidney Disease			Ulcerative Colitis		
Anger Issues			Seizure disorder (specify below)			Kidney Infection			Urinary Tract Infections		
Anorexia Nervosa			Ear/Nose/Throat Problems			Kidney Stones			Venereal Disease		
Anxiety			Endocrine/Metabolic Disorder			Malaria			Weight Loss/Gain		
Arthritis (specify below)			Fainting			Measles (specify below)			Allergy To:		
Asthma			Fractures (specify below)			Mononucleosis			Penicillin		
Back Problems			Frequent Colds or Sinusitis			Mumps			Sulfonamides		
Bipolar Disorder			Gall Bladder Disease			Orthopedic Problems			Other (specify below)		
Blood Disorders (specify)			Gastrointestinal/GERD/Reflux			Recurrent Headaches			Food (specify below)		
Bulimia			Head Injury (Serious/Unconscious)			Rheumatic Fever					
Cancer			Heart Murmur			Rubella (German Measles)			Surgery:		
Cerebral Palsy			Heart Palpitations			Scarlet Fever			Appendectomy		
Chicken Pox			Hepatitis (specify below)			Seasonal Allergies			Tonsillectomy		
Convulsive Disorder			Hernia			Self-harming Behavior			Wisdom Teeth Removed		
Crohn's Disease			High Blood Cholesterol			Skin Conditions			Other (specify below)		
Cystic Fibrosis			High Blood Pressure			Sleep Disorder			Last Dental Exam Date		
Cystitis/bladder Infection			Impaired Hearing			Suicidal Thought/Attempts					

Comments and/or explanation(s):

Medical History (Answer all questions)	Yes	No	Explain all "yes" answers below or on an additional sheet and attach.
Do you have any drug/medication allergy?			
Do you smoke?			
Do you consume alcohol?			
Do you use recreational drugs?			
Has your physical activity been restricted during the past five years?			
Have you had any illness or injury or been hospitalized other than already noted above?			
Do you have an ongoing health problem that has required treatment by a physician or other health care provider in the past five years?			
Have you received treatment by a psychiatrist or clinical psychologist?			
Do you take medication on a regular basis? If so, please list name(s) and dosage(s).			
Do you consider yourself challenged or disabled in any way that requires you to receive special consideration from RWC? If so, please specify.			

Student information:					
Name:				**Date of Birth:**	
Intercollegiate Sports(s)				**Gender:**	
Date of Physical:				**Year in School:** FR SO JR SR	
Examination *(Physical must be dated within a year) (Athletic physical must be dated within six months of sports participation)*					
Height:	**Weight:**	**BP:**	**Pulse:**	**BMI:**	
Vision Corrected: ❒ **Yes** ❒ **No** **L 20/** **R 20/**				**Pupils: Equal / Unequal**	

	Normal	Abnormal or significant findings
General		
Appearance		
HEENT		
Lung		
Heart Murmurs, (auscultation standing, supine)		
Endocrine/Lymph Nodes		
Abdominal		
Genialia (males only)		
Pulses Radial pulses & Simultaneous femoral		
Neurologic		
Skin		
Musculoskeletal		
Neck/Shoulder/Back		
Arm/Elbow/Wrist/Hand/Fingers		
Leg/Hip/Thigh/Knee		
Ankle/Foot/Toes		

Does the student have drug allergies? If yes, please list by name and type of reaction: _____

_____

Recommendations/Comments regarding the chronic condition or serious illness continuing care of the student:

_____

_____

Recommendations/Comments regarding the emotional, continuing care of the student:

_____

_____

❒ Cleared to participate in a full program college study

❒ Cleared for all sports without restrictions

❒ Cleared for all sport without restriction with recommendations for further evaluation or treatment for _____

❒ Not cleared for sports ❒ Not cleared for college study

❒ Pending further evaluation

Reason and recommendations _____

_____

Medical provider signature/stamp or a copy of the medical provider's document must be attached. **STAMP**

_____

MD, NP, or PA's Signature

_____

MD, NP, or PA's Printed Name

_____

Address, City, State

HEALTH CENTER | 2301 Westside Dr., Rochester, NY 14624-1997 | 585.594.6360 | Fax: 585.594.6920 | roberts.edu/healthcenter

REQUIRED

Records of the following are REQUIRED for International (F-1) Students attending Roberts Wesleyan College:

1. NYS Public Health Law 2165 & 2167 mandates students born after January 1, 1957 enrolled in six (6) credit hours or more to provide documented proof of immunity (vaccines or positive titer (blood test) results against measles, mumps, rubella and meningococcal meningitis disease:

Must fully complete ONE of the following three options:

Option 1	MMR #1 (Measles, Mumps, Rubella)	Date: _____/_____/_____
	MMR #2 (Measles, Mumps, Rubella)	Date: _____/_____/_____
Option 2	Measles #1 (Rubeola)	Date: _____/_____/_____
	Measles #2 (Rubeola)	Date: _____/_____/_____
	Mumps	Date: _____/_____/_____
	Rubella (German measles)	Date: _____/_____/_____
Option 3	Positive Measles Titer	Date: _____/_____/_____
	Positive Mumps Titer	Date: _____/_____/_____
	Positive Rubella Titer	Date: _____/_____/_____

2. NYSPHL Law 2167 mandates ALL students, **regardless of age**, to provide either proof of meningococcal vaccine or a signed declination statement rejecting the meningococcal vaccine.

Must fully complete ONE of the following two options:

Option 1	Meningococcal Vaccine Type: _____ Date: _____/_____/_____ (dated within 5 yrs)
Option 2	***Student elected not to be immunized against meningococcal meningitis disease.*** 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 decided **NOT** to be immunized against the meningococcal meningitis disease. Student's Signature: _____ Date:_____/_____/_____

3. Tuberculosis Screening (dated within a month before arriving to the states)

Must fully complete

ONLY Option	PPD (Mantoux) within the past year: Date placed: ____/____/____ Date read: ____/____/____ (within 48-72 hours) RESULT: ____ Negative ____ Positive _____ mm indurations *(If positive, chest x-ray report is mandated)*

Medical provider signature/stamp or a copy of the medical provider's document must be attached.

_____
MD, NP, or PA's Signature:

_____
MD, NP, or PA's Printed Name:

_____
Address, City, State:

STAMP

Immunization Record: *(must be completed and signed by medical provider or attach copy of the medical provider's record)*

Student's Name: _____ **Date of Birth:** _____/_____/_____

RECOMMENDED

The following immunizations are suggested for International (F-1) Students attending Roberts Wesleyan College:

Tetanus/Diphtheria/Pertussis	Date: _____/_____/_____ (dated within 10 years)		
Hepatitis A	#1 Date: ____/____/____ #2 Date: ____/____/____	**OR**	Positive Titer Date: ____/____/____
Hepatitis B	#1 Date: ____/____/____ #2 Date: ____/____/____ #3 Date: ____/____/____	**OR**	Positive Titer Date: ____/____/____
Polio Booster	Date: ____/____/____		
Seasonal Flu vaccine	Date: ____/____/____		
Varicella	History of Varicella disease: Yes _____ No _____ Date: ____/____/____ #1 Date: ____/____/____ #2 Date: ____/____/____	**OR**	Positive Titer Date: ____/____/____

Medical provider signature/stamp or a copy of the medical provider's document must be attached.

_____
MD, NP, or PA's Signature:

_____
MD, NP, or PA's Printed Name:

_____
Address, City, State:

STAMP