



# WALKER HEALTH CENTER HEALTH HISTORY and IMMUNIZATION FORM

Mary Walker Health Center  
State University of New York at Oswego  
Oswego, NY 13126

**OFFICIAL USE ONLY**

Meas. Imm.  Returned Date Initials

**Instructions and Information**

Please provide the following information as completely as you are able. Information on this form is CONFIDENTIAL and is used for your health and safety while you are a student. Information will be released only with your written permission or with a court order. Call 315-312-4100 with questions. FAX number: 315-312-5409.

**IDENTIFICATION:**

SIGNATURE \_\_\_\_\_

Social Security Number \_\_\_\_\_

Year Entering 20 \_\_\_\_\_ Fall \_\_\_\_\_ Spring \_\_\_\_\_

Student Status  Freshman  Transfer  Re-admit  Graduate

PRINT NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

Telephone Number: Home ( \_\_\_\_\_ ) \_\_\_\_\_

Cell Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_

Birth Date: Month/Day/Year \_\_\_\_\_

Gender: Male \_\_\_\_\_ Female \_\_\_\_\_

Country of Birth \_\_\_\_\_

Citizenship: US \_\_\_\_\_ OTHER (specify) \_\_\_\_\_

**During the last five years, have you lived outside the US or your home country for a month or more?**  Yes  No  
Where? \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Father's Name: \_\_\_\_\_

**PERSON TO NOTIFY IN CASE OF AN EMERGENCY:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

( \_\_\_\_\_ ) \_\_\_\_\_

Home Telephone Number \_\_\_\_\_

( \_\_\_\_\_ ) \_\_\_\_\_

Business Telephone Number \_\_\_\_\_

**YOUR LIFESTYLE: ARE YOU . . .**

- |                          |                          |  |
|--------------------------|--------------------------|--|
| YES                      | NO                       |  |
| <input type="checkbox"/> | <input type="checkbox"/> | A consistent seat belt user?               |
| <input type="checkbox"/> | <input type="checkbox"/> | A cigarette smoker?                        |
|                          |                          | Packs per day _____                        |
|                          |                          | Number of years smoking _____              |
| <input type="checkbox"/> | <input type="checkbox"/> | Concerned about your weight?               |
| <input type="checkbox"/> | <input type="checkbox"/> | An alcohol consumer?                       |
|                          |                          | How many per day? _____ per week? _____    |
| <input type="checkbox"/> | <input type="checkbox"/> | Performing testicular or breast self exam? |

**HEALTH: Answer All Questions**

Describe any treatment you are currently receiving: \_\_\_\_\_

**List any current medications:**

- |                          |                          |   |
|--------------------------|--------------------------|---|
| YES                      | NO                       |   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you plan to receive allergy shots at college? (You must bring your allergist's instructions and a current schedule of injections.) |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you <b>allergic</b> to medications? <b>List them:</b> _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you <b>allergic</b> to foods? <b>List them:</b> _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Latex allergy?  |

**AUTHORIZATION: FOR ALL STUDENTS UNDER THE AGE OF 18**

Signature of parent/guardian indicates SUNY Oswego Walker Health Center has permission to provide medical care or emergency treatment for your child. This includes care and treatment by other consultants, if deemed necessary.

Signature of Parent / Guardian \_\_\_\_\_

Daytime Phone Number \_\_\_\_\_

Home Phone Number (if different) \_\_\_\_\_

**HEALTH INSURANCE INFORMATION:**

- **Must cover OUTPATIENT healthcare in this community.**
- **Student should have his/her own insurance card!**
- **Is pre-authorization required?**  Yes  No  
If "yes", phone # to call: \_\_\_\_\_

Ins. Company Name \_\_\_\_\_

Ins. Company Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

Insured's Name \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Policy Number \_\_\_\_\_

Plan Code \_\_\_\_\_

Group Number \_\_\_\_\_

**Is PRESCRIPTION COVERAGE included with this plan?** Yes  No if "Yes", Co-pay amount \_\_\_\_\_

**PAST MEDICAL HISTORY:**

Have you had any of the following problems?:

- Anemia
- Asthma
- Bladder/Kidney Infection
- Cancer or Malignancy
- Chicken Pox (date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ )
- Chronic Inflammatory Bowel Disease
- Emotional Illness
- Hepatitis
- Infectious Mononucleosis
- Knee Injury
- Obesity
- Phlebitis
- Other \_\_\_\_\_
- Polio
- Rheumatic Fever
- Thyroid Disease
- Tuberculosis
- Treatment to prevent Tuberculosis
- Sexually Transmitted Disease such as: Chlamydia, HIV, HPV, Pelvic Inflammatory Disease
- Vaginitis, i.e. Trichomonas, Monilia, or Bacterial Vaginosis
- Surgery \_\_\_\_\_

I have read this section and none apply.

**FAMILY MEDICAL HISTORY:**

Please check below if any blood relatives have/had any of the diseases listed. Mother (M), Father (F), Siblings (S), Grandmother (GM), Grandfather (GF), Children (C)

YES	WHO	
_____	_____	Alcoholism
_____	_____	Allergy/Asthma
_____	_____	Bleeding Problems
_____	_____	Cancer _____
_____	_____	Diabetes
_____	_____	Epilepsy
_____	_____	Headache
_____	_____	Heart Disease
_____	_____	High Blood Pressure
_____	_____	Kidney Disease
_____	_____	Mental Problem
_____	_____	Nervous Problem
_____	_____	Obesity
_____	_____	Ulcer
_____	_____	Tuberculosis

**IS THERE ANY OTHER INFORMATION ABOUT YOUR MEDICAL HISTORY OR CURRENT MEDICAL NEEDS WE SHOULD KNOW?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**WHO IS YOUR CURRENT HEALTH CARE PROVIDER?**

Name (print): \_\_\_\_\_

Phone: \_\_\_\_\_

**CURRENT MEDICAL STATUS:**

Are you under treatment for or have you had any of the following with in the PAST YEAR?:

- Arthritis/Joint Problems
- Asthma
- Attention Deficit Disorder
- Bleeding/Blood Disorder
- Cancer \_\_\_\_\_
- Chronic Skin Condition or Eczema
- Diabetes
- Digestive Problems
- Disabling Condition
- Dizziness/Fainting
- Eating Disorders including binging
- Emotional Problems, Depression or Anxiety
- Frequent Colds
- Hay Fever, Allergies
- Hearing Impairment
- Heart Disease
- High Blood Pressure
- Irritable Bowel Syndrome
- Kidney/Bladder Infection
- Painful Menstruation
- Recurrent Diarrhea/Constipation
- Recurrent Headaches/Migraine
- Seizure Disorder (epilepsy)
- Visual Impairment

Explain: \_\_\_\_\_

\_\_\_\_\_

Other \_\_\_\_\_

I have read this section and none apply.

**OPTIONAL PHYSICAL EXAM:**

Suggested for students with chronic or special health needs or for students planning to participate in intercollegiate athletics.

Blood Pressure \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

**PHYSICAL EXAM**

Skin:

H.E.E.N.T.:

Neck:

Lymph Nodes:

Chest & Breasts:

Lungs:

Heart:

Abdomen:

Pelvic, Rectal, and Genitalia:

Skeletal & Extremities:

Neurological:

Please comment about student's physical and mental status including restrictions:

Signature: \_\_\_\_\_ MD/NP/PA

Print Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Transfer your immunization information to this Health Form *and* have your doctor, nurse practitioner, physician’s assistant or school nurse sign the form.

**IMMUNIZATION RECORD REQUIRED\* (Dates Must Be Written Mo/Day/Yr): Please read attach letter for detailed instructions.**

DISEASE	Vaccine Date Given Mo/Day/Yr	Vaccine Manufacturer	Vaccine Lot Number	Initials of Vaccine Administrator OR certifying health professional	Physician Diagnosed Disease History (date onset)	Serology Date/Results (copy of lab report <b>MUST be attached</b> )
MEASLES* <sup>1</sup>	# 1					
	# 2					
MUMPS* <sup>2</sup>						
RUBELLA* <sup>3</sup>						
OR COMBINED MMR* <sup>1 &amp; 2</sup>	# 1	Merck				
	# 2	Merck				
TETANUS/DIPHThERIA* <sup>4</sup> Tetanus Diphtheria Tdap						
VARICELLA Recommended	# 1					
	# 2					
HEPATITIS B Recommended	# 1					
	# 2					
	# 3					
MENINGOCOCCAL MENINGITIS VACCINE Recommended: OR Menomune Menactra	# 1					

**New York State Law requires all entering college students to have:**

- 1 Two doses of LIVE virus measles (rubeola) vaccine (live vaccine was available after 1/1/68) at least 30 days apart. The first dose of live virus vaccine administered after the age of 12 months. A second dose administered more than 30 days after the first but after 15 months of age.
- 2 LIVE virus mumps vaccine (live vaccine was available after 1/1/68) administered after the age of 12 months.
- 3 LIVE virus rubella vaccine (live vaccine was available after 1/1/68) administered after the age of 12 months.
- 4 Within 10 years.

\* **NOTE:** Students born before 1/1/57 do not need to fulfill measles, mumps, rubella requirement. Required for international students.

**SIGNATURE REQUIRED:**

**I certify that the above immunization information is complete and accurate to the best of my knowledge:**

Signature of provider or school official (MD, NP, PA, RN)

Date

Print name and address of certifying provider or school official

**OFFICE USE ONLY: ppd testing will be done at Walker Health Center on students at risk for TB.**

TEST	CXR	Date placed Mo/Day/Yr	Manufacturer	Date Read	Size of Induration	Reader Initials
PPD						

**IMPORTANT INFORMATION TO HELP YOU FILL OUT THIS FORM CORRECTLY**

- **Immunization and health history for student to fill out and return**
- **Optional Physical Exam**

Walker Health Center and its professional staff welcome you to Oswego State. Pay attention to the following information to help you meet the health clearance requirements by *correctly* completing this Health History and Immunization Form. *Students who do not comply or fully meet this requirement will be restricted from class attendance.*

**Where can you obtain an acceptable record of your immunizations?**

- **High School** - These records must contain adequate information (the month, day, year) for each immunization.
- **Personal Immunization Records** - Transfer immunization information to this form and have your MD, NP, PA, or school nurse sign the form.
- **Local Health Departments** - If primary immunizations were received at your County Health Department request a certified copy from there.
- **Transfer Students** - Obtain a copy of your immunizations from your previously attended school by getting in direct contact with the Health Service.
- **Meningococcal Meningitis vaccine** - Newly recommended for students living in college residence halls. Meningococcal Meningitis is a rare, very serious, and potentially fatal disease. Certain strains of the disease can be prevented by vaccination. The vaccination has a lasting effect of up to 10 years. Talk to your health care provider about the need for this vaccine. The vaccine is available at Walker Health Center at a reasonable price. Call 315-312-4100 to discuss this.

**For further information, please contact Walker Health Center at 315-312-4100 Monday through Friday 9 a.m. to 4 p.m.**

**INSTRUCTIONS:**

Follow printed instructions for each section of this form and then mail it directly to Walker Health Center. Complete the Personal Information and Health Insurance Information. Insurance information is necessary if you need outpatient laboratory or x-ray services as an adjunct to your care at Walker Health Center as well as for emergencies.

**The Immunization Record is extremely important and complex.**

***You cannot live on campus or attend class if this information is incomplete or inaccurate, and/or a Certifying Signature is not included.***

- Review the requirements carefully with your school nurse, health care provider, or clinic.
- Record previous immunizations and submit with your clinician's signature (nurse, nurse practitioner, physician assistant, or physician).
- Update vaccines as indicated by the stated standards.
- Exemptions are considered for medical or religious reasons only. All exemption requests must be in writing with all details of request included.
- Skin testing for tuberculosis exposure will be performed on campus at Walker Health Center for persons born or having residence in environments with endemic tuberculosis or students needing testing for community service or employment.

**Health Insurance information - including this information will ease student access to referrals.**

***Before waiving the Oswego State Student Health Insurance Plan, be sure your current coverage can be used for OUTPATIENT SERVICES (lab costs, x-rays) and specialist referrals in this community.***

**Personal and Medical History**

- Complete as accurately as possible with all necessary explanations included. Accuracy of information will allow our providers to provide safe health care.

**Permission to treat underage students**

- Parents of students *under 18 years of age* must complete this section.

**OPTIONAL PHYSICAL EXAM: Who should have a physical?**

- Students planning to participate in intercollegiate athletics.
- Any student with a history of chronic disease (asthma, diabetes, arthritis, cancer, heart, kidney, endocrine, lung disease, or any eating disorder).

Due Date: June 1 for Fall admission  
December 1 for Spring admission

Return the form to: Walker Health Center, Bldg. #10  
State University of New York at Oswego  
Oswego, NY 13126