STUDENT HEALTH SERVICES ENTRANCE HEALTH EVALUATION

PLEASE MAIL DIRECTLY TO: IONA COLLEGE WELLNESS CENTER
715 NORTH AVENUE, NEW ROCHELLE, NY 10801.
PHONE: (914) 633-2548 FAX: (914) 712-4102.

TO THE STUDENT:

This health form is the foundation of your medical record at college and is required for all students. Basic to good health is the university's knowledge of the health status of each student. It is filed at the Student Health Service for reference to be used whenever a consultation for illness or a conference for health appraisal takes place.

The information contained in this form is accessible only to the professional staff of Health Services and will not be released without the written authorization of the student or pursuant to a lawfully issued subpoena. The authority to request this information is found in section 355 of the Education Law.

YOU SHOULD COMPLETE THE PERSONAL INFORMATION SECTION BEFORE GOING TO A PHYSICIAN FOR EXAMINATION. SUBMIT THE COMPLETED FORM NO LATER THAN *JULY 1* FOR FALL SESSION AND JANUARY 1ST FOR SPRING SESSION. *(COMMUTER STUDENTS NEED COMPLETE PAGES 1, 2 & 3 ONLY.)*

Any physical examination performed **in the last year** is acceptable as are records from a previous university/college health service. An official written request for transfer of the records must be sent by the student to the record holder with permission for the medical release of the records to Iona's Student Health Services. A physical examination that has not been submitted according to the policy above, will be performed at Health Services for $40.00.

This information is **confidential**. It is strictly for the use of the Health Service and will not be released to anyone without your knowledge and consent. **Please make a copy for your records.**

Student, Parent/Guardian and Emergency Information

STUDENT ID#_____ Year of Enrollment _____

Name: _____ Birthdate: _____
Last First MI

Address: _____ Home Phone: ( ) _____
Street City State Zip

Boarding Address: _____ Boarding Phone: ( ) _____

_____

Sex: ☐ Male ☐ Female

Class entering: ☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ Graduate

Enrollment Status: ☐ Full time ☐ Part time

Place of Birth: _____

Name and Address of both Parents/Guardians

Name: _____ Name: _____

Address: _____ Address: _____

Phone: ( ) _____ Phone: ( ) _____

Persons to be notified in case of emergency

Name: _____ Relationship: _____

Home Phone: ( ) _____ Business Phone: ( ) _____

List any Medic Alert: _____

PERSONAL HEALTH HISTORY - PLEASE ANSWER ALL QUESTIONS

Please check Yes or No and comment on all positive responses in comments space below.

	Y	N		Y	N		Y	N
Scarlet Fever Disease			Recurrent Headaches			Stomach or Intestinal Trouble		
Measles Disease			Recurrent Colds			Gallbladder Trouble		
German Measles Disease			Allergies (specify): Penicillin			Jaundice or Hepatitis		
Mumps Disease			Allergies: Other Drugs			Recurrent Diarrhea		
Chicken Pox Disease			Hay Fever, Asthma			Surgery (list with dates in space provided)		
Mononucleosis Disease			Chronic Cough			Head injury with unconsciousness		
Malaria Disease			Rheumatic Fever			Trauma Injury		
Eye Trouble			Heart Murmur			Transfusions		
Ear, Nose, Throat Trouble			Pain/Pressure in Chest			Recent Weight Loss/Gain		
Sinusitis			Palpitation (Heart)			Tuberculosis or Positive TB Test		
Hearing Difficulty			Shortness of Breath			Venereal Disease		
Speech Difficulty			High Blood Pressure			Albumin in Urine		
Insomnia			Dizziness or Fainting			Sugar in Urine		
Frequent Anxiety			Convulsions or Epilepsy			Frequent Urination		
Frequent Depression			Arthritis, Rheumatism, Joint Trouble			Urinary Tract Infections		
Worry or Nervousness			Back Problems			Painful Urination		

PLEASE COMMENT ON ALL POSITIVE RESPONSES IN SPACE BELOW.

(Give details, reasons, and dates as appropriate).

	Y	N
Has your physical activity been restricted or your education interrupted for medical reasons during the past five years?		
Have you had difficulty with school, studies, or teachers?		
Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem?		
Have you had any illness or injury or been hospitalized other than already noted? (Describe below)		
Have you consulted or been treated by clinics, physicians, healers or other practitioners within the past five years (other than routine checkups)?		
Have you been rejected for or discharged from military service because of physical, emotional, or other reasons?		
Do you have the absence of any paired organ (eye, ear, kidney, etc.)?		

Family History

	Age	State of Health	Occupation	Age at Death	Cause of Death
Father					
Mother					
Brother(s)					
Sister(s)					

	Yes	No	Relationship
Tuberculosis			
Diabetes			
Kidney Disease			
Heart Disease			
High Blood Preasure			
Arthritis			
Stomach Disease/Ulcer			
Asthma, Hay Fever, Eczema			
Epilepsy, Convulsions			
Cancer			
Emotional Trouble			
Anemia			
Alcohol/Drug Abuse			

PERMISSION FOR TREATMENT FOR STUDENTS UNDER 18 YEARS OF AGE

When serious medical problems arise, every effort will be made to reach parents or guardians. On occasion, we are unable to make this contact. To avoid delay in treatment, we request that the following statement be signed by a parent or guardian.

I hereby grant permission to treat and/or hospitalize my son/daughter/ward in case of illness.

_____

Signature of Parent or Guardian Date

_____

Relationship

Student's Name _____ STUDENT ID# _____

Persons born before January, 1957, are exempt from this requirement and do not need to submit this form.

All Commuter and Resident students MUST have <u>Sections A and E</u> OR <u>Sections B, C, D, and E</u>

Completed in order to be in compliance with the NY State Public Health Laws.

Month / Day / Year

A: M.M.R. (Measles, Mumps, Rubella) If given instead of individual immunization

1st Dose: Immunized on or after first birthday, AND on or after January 1, 1972 ____/____/____

2nd Dose: Immunized 15 months after birth or later, AND at least 28 days after 1st dose. ____/____/____

B: MEASLES (RUBEOLA)

1. ____ Had the disease, confirmed by office record ____/____/____
2. ____ Has reports of adequate immune titer. **MUST SUBMIT COPY OF LAB REPORT** ____/____/____
3. ____ Dose 1: Immunized on or after first birthday, AND on or after January 1,1968 ____/____/___

AND

Dose 2: Immunized 15 months after birth or later AND at least 28 days after 1st dose. ____/____/____

C: MUMPS

1. ____ Had the disease, confirmed by office record ____/____/____
2. ____ Has reports of adequate immune titer. **MUST SUBMIT COPY OF LAB REPORT** ____/____/____
3. ____ Immunized on or after first birthday, AND on or after January 1,1968 ____/____/____

D: RUBELLA (GERMAN MEASLES)

1. ____ Has reports of adequate immune titer. **MUST SUBMIT COPY OF LAB REPORT** ____/____/____
2. ____ Immunized on or after first birthday, AND on or after January 1,1968 ____/____/____

E: MENINGOCOCCAL MENINGITIS - Required for ALL Resident Students

Check one box.

☐ Had the meningitis immunization (Menomune™/Menactra™) within the past 5 years. ____/____/____

☐ Read or have 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.

F. STRONGLY RECOMMENDED FOR RESIDENT STUDENTS

_____ PPD Result _____ ____/____/____

_____ Tetanus or TD (within 10 years) ____/____/____

_____ Polio Series Completes ____/____/____

_____ Hepatitis #1 ____/____/____

#2 ____/____/____

#3 ____/____/____

____ Varicella (If No History of the Chicken Pox) ____/____/____

Physician's Signature and Stamp _____ Date: _____

PHYSICAL EXAMINATION REQUIRED FOR ALL RESIDENT STUDENTS

Student's Name _____ STUDENT ID#_____

To the Examining Practitioner:
Please review the student's history and complete applicable parts of the examination form. Please comment on all positive answers. THIS STUDENT HAS BEEN ADMITTED TO THE COLLEGE. The information will not be used to influence status at the college; it will be used only as a background for providing health care, if necessary, while enrolled as a student. This information is confidential and will not be released to anyone without the student's knowledge and consent. Thank you.

Height _____ Weight_____ Blood Pressure _____ / _____ Pulse _____

Vision OD _____ OS_____ Corrected? Y_____ N _____ Urinalysis:_____

	Normal	Abnormal
Head, Ears, Nose, or Throat		
Eyes (Fundoscopic)		
Hearing		
Neck-Thyroid		
Respiratory		
Cardiovascular		
Gastrointestinal		

	Normal	Abnormal
Hernia		
Genitourinary		
Musculoskeletal		
Metabolic/Endocrine		
Neurological		
Skin		
Psychosocial		

	Yes	No
To the best of your knowledge, is this person free from physical or mental impairments including alcohol, drug dependency?		
Are there any restrictions of physical activity indicated by your examination? Comment below.		
Is the patient now under treatment for any medical or emotional condition? Comment below		
Do you have any recommendations regarding the care of this student? Comment below		
How long and in what capacity have you known this student?		

MEDICATION

Are you currently taking any medication? ☐ No ☐ Yes, Please list

Comments: _____

_____

_____

_____

Physician's Signature and Stamp _____

Name_____ Phone ( )_____

Address _____

City/State/Zip_____ Date of Examination _____

_____

RESIDENT STUDENTS PLEASE LIST ALL HEALTH INSURANCE COVERAGE

HEALTH INSURANCE COMPANY:	SUBSCRIBER NAME:
Address of company:	Policy #:
Telephone #:	Group #:

PLEASE ATTACH A COPY OF BOTH SIDES OF INSURANCE CARD TO THIS FORM