



HEALTH REPORT

Student's Name _____

Please read, respond, and return this Health Report to:

Health Office
Cayuga Community College
197 Franklin Street
Auburn, NY 13021

New York State Public Health Law 2167 requires colleges to distribute information about meningococcal disease and vaccinations to ALL students taking 6 credit hours or more (on campus). A signed reply is then required from the student. This report includes the reply section for your signature.

New York State Public Health Law 2165 requires proof of immunity to measles, mumps and rubella. This law is mandatory for ALL college students born in 1957 or later and registered for six (6) credit hours or more (on campus).

Students who will work in the campus **Preschool Center** as part of their curriculum must have a physician complete Part V—Preschool Center Students Only section of this report.

Nursing and Occupational Therapy Assistant Students are required to have an annual physical examination (use last page of this report) and must complete Part IV—Nursing and Occupational Therapy Assistant Students Only section in this report.

Members of College **athletic teams** are also required to have an annual physical examination (use last page of this report).

Information recorded on this form is confidential and will not be shared outside of this institution without your consent.

myCayuga ID Number _____

Cayuga Community College

197 Franklin Street • Auburn NY 13021

C# C_____ Date of Birth_____/_____/_____

Name_____

Last	First	Middle
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Home Address _____

Number and Street	City	State	Zip
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Phone (____) _____

Address while attending Cayuga _____

Number and Street	City	State	Zip
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Person to notify in case of emergency _____ Phone (____) _____

HEALTH HISTORY

Place mark the appropriate box(es):

____ Anemia	____ Diarrhea (recurrent)	____ Hepatitis	____ Tuberculosis
____ Arthritis	____ Diabetes	____ Jaundice	____ Ulcerative Colitis
____ Asthma	____ Digestive Problems	____ Joint Disease/Injury	____ OTHER (specify):
____ Back Problems	____ Dizziness/Fainting	____ Kidney Disease	_____
____ Blood Disorder	____ Ear Trouble	____ Pneumonia	_____
____ Chicken Pox	____ Eye Trouble	____ Rheumatic Fever	_____
____ Colds (frequent)	____ Hay Fever	____ Scarlet Fever	_____
____ Convulsion/Seizure	____ Headaches (recurrent)	____ Sinusitis	_____
____ Depression	____ Heart Problem/Murmur	____ Sore Throat (frequent)	

** Disclosure of personal information is voluntary and does not affect your acceptance at Cayuga*

Please list any allergies to food, drugs, etc. _____

Do you take any medications regularly? ____ Yes ____ No If "Yes," please list drug(s) and dosage(s) _____

Please list any serious injuries, illness, fractures, dislocations or surgeries: _____

Do you have any disability or impairment of which we should be aware? _____

Are you currently receiving treatment at a clinic or by a physician (other than regular check-ups)? ____ Yes ____ No

If "Yes," please explain: _____

IMMUNIZATION RECORD

PART I: REQUIRED by NYS PHL 2165

1. REQUIRED MMR (Measles, Mumps, Rubella)

Date of MMR #1 _____ Date of MMR #2 _____

OR

Date of MEASLES VACCINE _____ Date of TITER _____ Results _____

Date of MUMPS VACCINE _____ Date of TITER _____ Results _____

Date of RUBELLA VACCINE _____ Date of TITER _____ Results _____

PART II: REQUIRED by NYS PHL 2167

Meningococcal Meningitis vaccine (check one only)

_____ Had meningococcal meningitis vaccine within past 5 years Date _____ **Attach Record**

_____ 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 at this time. I understand that I may choose to seek vaccination in the future.

Signature of Student (Parent/Guardian for student <18)

Date

PART III (voluntary)

Covid 19 Vaccination (attach record)

Initial Series: Brand _____ Date of Dose 1 _____ Dose 2 _____

Booster: Brand _____ Date of Booster1 _____ Booster 2 _____

Additional Booster _____

PART IV: NURSING STUDENTS

1. REQUIRED TB Tuberculin Skin Test (PPD) (yearly)

Date of PPD _____ Results _____

If Positive PPD Date of Chest X-ray _____ Results _____

2. REQUIRED Tetanus (TDAP) within 10 years

Date of TDAP _____ **OR** Date of TD _____

3. REQUIRED Chicken Pox/Varicella

Date of CP Disease _____ **OR** Date of Antibody Titer _____ Results _____

OR Date of CP Vaccine #1 _____ #2 _____

4. RECOMMENDED Hepatitis B Vaccine Series

Date of Hep B #1 _____ Hep B #2 _____ Hep B #3 _____

OR Date of Antibody Tite _____ Results _____ Results _____

OR Declination of Hepatitis Vaccination _____
Signature _____ Date _____

Signature of Physician/NP/PA

Date

PHYSICAL EVALUATION (To be completed by the Physician/NP/PA)

Name: _____

Legal Sex: (optional) ___ Male ___ Female Height _____ Weight _____

Blood Pressure: Sitting _____ Standing _____

Uncorrected Vision: Rt. 20/___ Left 20/___ Corrected Vision: Rt. 20/___ Left 20/___/

Are there any irregularities of the following systems?

	Yes	No	Use this area to describe fully any positive findings and clarify recommendations:
Head	___	___	
Neck	___	___	
Eyes	___	___	
Ears	___	___	
Nose	___	___	
Throat and Teeth	___	___	
Heart	___	___	
Lungs	___	___	
Breasts	___	___	
Abdomen	___	___	
Genito-Urinary	___	___	
Extremities	___	___	
Skin	___	___	
Skeletal	___	___	

Recommendations for physical activity (physical education, nursing clinicals, intercollegiate sports):

☐ Unlimited ☐ Limited If "Limited," please explain: _____

Signature of Physician/NP/PA _____ Date _____

Address _____

Phone () _____

Please return this form to:

*College Health Service Office
Cayuga Community College
197 Franklin Street
Auburn, NY 13021-3099*