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.
### HEALTH HISTORY

Place an “X” in the appropriate box(es):

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

*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:_____________________________________________________

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Social Security # __________________________ Date of Birth __________________________

Name __________________________ __________________________ __________________________

Home Address __________________________ __________________________ __________________________

Number and Street __________________________ __________________________ __________________________

City __________________________ State __________________________ Zip __________________________

Phone (with area code) __________________________

Address while attending Cayuga (if same as above, write “SAME”): __________________________

Address at school __________________________

Phone (with area code) __________________________

Person to notify in case of emergency __________________________

Phone (with area code) __________________________
IMMUNIZATION RECORD

Part I: REQUIRED A or B by NYS PHL 2165

A. M.M.R. (Measles, Mumps, Rubella) 2 doses required.  Date of MMR #1 ______________  Date of MMR #2 ______________

OR

B. Measles (Rubeola) 2 dates of measles immunization. Both doses must be given after 1967.

First Date ___________________________  Second Date ___________________________

OR Date of Measles Titer ___________________________ Results  □ Positive  □ Negative

Mumps Date of at least one mumps immunization.  First Date ___________________________  Second Date ___________________________

OR Date of Mumps Titer ___________________________ Results  □ Positive  □ Negative

Rubella (German Measles) Date of at least one rubella immunization.  First Date ___________________________  Second Date ___________________________

OR Date of Rubella Titer ___________________________ Results  □ Positive  □ Negative

Part II: REQUIRED A or B by NYS PHL 2167

Meningococcal Meningitis vaccine (check one box only)

A. □ Had meningococcal meningitis vaccine within past 5 years (Menomune™ Menactra™, Menveo™) Date __________ Attach Record

B. □ 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 under age 18) _________________________________________ Date __________

Part III: RECOMMENDED VACCINES AND TESTING

Tetanus (TD) Booster Date ______________ (within 10 years)

Tuberculin Skin Test (PPD) Test Date ______________ Results  □ Positive  □ Negative

Hepatitis B Vaccine:  Date #1 ______________  Date #2 ______________  Date #3 ______________

Part IV: NURSING AND OTA STUDENTS ONLY

1. REQUIRED MMR (Measles, Mumps, Rubella)

Date of MMR #1 ______________  Date of MMR #2 ______________

OR

Date of MEASLES TITER ___________________________ Results __________________

Date of MUMPS TITER ___________________________ Results __________________

Date of RUBELLA TITER ___________________________ Results __________________

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

Date of PPD ______________ Results __________________

If Positive PPD, date of Chest X-ray ______________ Results __________________

3. REQUIRED Tetanus (TD) within 10 years

Date of TD ______________ OR Date of TDAP ______________

4. REQUIRED Chicken Pox/Varicella

Date of CP Disease ___________________________ OR Date of Antibody Titer ___________________________ Results __________________

OR Date of CP Vaccine #1 ___________________________  #2 ___________________________

5. RECOMMENDED Hepatitis B Vaccination Series

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

OR Date of Antibody Titer ___________________________ Results __________________

OR Declination of Hepatitis Vaccination ____________________________________

Signature ___________________________ Date __________

Part V: PRESCHOOL CENTER STUDENTS ONLY

1. Is this person free of communicable diseases?  □ Yes  □ No

2. Is this person physically fit to take part in this program?  □ Yes  □ No

3. Tuberculin skin test (PPD) Date ______________ Results __________________

Signature of Physician/NP/PA ___________________________ Date __________
**PHYSICAL EVALUATION** (To be completed by the Physician/NP/PA)

Name: ______________________________________________________________________________________________________

Sex:  □ 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?

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<th>No</th>
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Use this area to describe fully any positive findings and clarify recommendations:

________________________________________________________________________________________________________________

________________________________________________________________________________________________________________

**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