PrattMWP
COLLEGE OF ART AND DESIGN

PHYSICAL/IMMUNIZATION FORM

Fall 2018 – Spring 2019

The following four pages should be **completed by your healthcare provider**,
no more than one year prior to enrollment.
Due by Friday, June 29, 2018.

STUDENT INFORMATION

Last Name	First Name	M.I.

Birth Date (*month/day/year*)	Physical Exam Date

PHSYICAL EXAM

Height: _____ Feet _____ Inches **Weight:** _____lbs **Pulse:** _____per min. **Blood Pressure:** _____

Hearing: R_____ L _____ **Hearing Aid:** _____

Vision: Uncorrected: R_____ L_____ Corrected: R_____ L_____ Glasses/Lenses: _____

Current medications and plans to continue them at PrattMWP:

Please comment on the following:	
Skin	
PMH	
HEENT	
Lungs/Chest	
Breasts	
Heart/Vascular System	
Abdomen	
Genitourinary	
Pelvic	
Muscular/Skeletal	
Neurological	
Endocrine	
Psychiatric	

Diagnosis/Treatment/Recommendation:

STUDENT NAME: _____ **D.O.B.** _____

TUBERCULOSIS SCREENING REQUIRED:

Must be completed by your health care provider

1. Does the student have signs or symptoms of active TB?
   - ☐ **YES.** Proceed with additional evaluation to exclude active TB disease, including tuberculin skin testing, IGRA Blood Test, chest X-ray, and sputum evaluation as indicated
   - ☐ **NO.** Proceed to question two.
2. Has the student traveled/lived in a high incidence country?
   - ☐ **NO.** Stop, no further evaluation at this time.
   - ☐ **YES.** Perform TB Skin Test OR IGRA Blood Test OR Chest X-ray.

TB Skin Test: Date Place: _____/_____/_____ Date Read: _____/_____/_____ Result: _____mm

Interpretation (based on mm of induration, as well as risk factors: ____Negative ____Positive

IGRA Results: ____Negative ____Positive ____Indeterminate (please attach)

If either test is positive, or there is a history of a past positive PPD, a chest X-ray is required.

Result: ____Normal ____Abnormal Date of X-ray: _____/_____/_____

Dates of treatment, including medication dose and frequency:

As requested by PrattMWP, I certify that I have, on this date, examined this student. On the basis of this examination and the student's medical history as furnished to me:

- ☐ The student is cleared to participate in supervised college activities, including athletics.

- ☐ The student is cleared WITH RESTRICTIONS to participate in supervised college activities, including athletics.
  Restrictions:

- ☐ The student is NOT cleared to participate in supervised college activities, including athletics.
  Reason:

If conditions arise after the student is cleared for participation, the provider may rescind the clearance until the problem is resolved.

EXAMINER'S SIGNATURE REQUIRED

Examiner's Name (Print/Stamp):_____

Address:_____

Phone Number:_____

Signature/Title:_____ Date:_____

IMMUNIZATION RECORDS

STUDENT NAME: _____ **D.O.B.** _____

New York State Public Health Law 2165 REQUIRES proof of two measles, one mumps, and one rubella immunization on or after the first birthday.

☐ **This student was born before January 1, 1957 and therefore is considered immune to measles, mumps and rubella.**

OR
M.M.R. (Measles, Mumps, Rubella) administered instead of individual immunizations.

1) Dose 1-Immunized at 12 months or after: (Date: Month, Day, Year) _____/_____ /_____
2) Dose 2-Immunized at least 1 month later: (Date: Month, Day, Year) _____/_____ /_____

OR
MEASLES (Rubeola) Immunity *(check all that apply)*

☐ TWO dates of Measles Immunizations. Dose 1: (Date: Month, Day, Year) _____/_____ /_____
Dose 2: (Date: Month, Day, Year) _____/_____ /_____

☐ Date of physician diagnosed measles disease: (Date: Month, Day, Year) _____/_____ /_____

RUBELLA (German Measles) Immunity
Physician diagnosis is not acceptable for Rubella immunity.

Date of Rubella Immunization: (Date: Month, Day, Year) _____/_____ /_____

MUMPS Immunity. *(Must have one of the following)*

☐ Date of Mumps Immunization: (Date: Month, Day, Year) _____/_____ /_____

☐ Date of physician diagnosed measles disease: (Date: Month, Day, Year) _____/_____ /_____

OR
MMR Titer (blood test showing positive immunity, dated laboratory results **MUST BE ATTACHED**)

(Date: Month, Day, Year) _____/_____ /_____

MENINGITIS: NYS Public Health Law 2167. Please refer to enclosed information regarding Meningitis and complete form.

Date Meningitis vaccine *(Menomune)*: (Date: Month, Day, Year) _____/_____ /_____

OR

Complete and sign the separate Meningitis Response Form found in this packet.

RECOMMENDED IMMUNIZATIONS

HEPATITIS A #1 _____/_____ /_____ #2 _____/_____ /_____

HEPATITIS B #1 _____/_____ /_____ #2 _____/_____ /_____ #3 _____/_____ /_____

VARICELLA (Chicken Pox) #1 _____/_____ /_____ #2 _____/_____ /_____

TETANUS-DIPTHERIA *(Primary series with DtaP or DTP and booster with Td in the last 10 years, meets requirement)*
_____/_____ /_____

POLIO *(Completed primary series of Polio immunization)* _____/_____ /_____

HPV #1 _____/_____ /_____ #2_____/_____ /_____ #3 _____/_____ /_____

PHYSICIAN/HEALTH PROVIDER NAME (print): _____

PHYSICIAN/HEALTH PROVIDER SIGNATURE:_____ **DATE:** _____

STUDENT NAME: _____ **D.O.B:** _____

MENINGITIS VACCINATION RESPONSE

New York State Public Health Law requires all college students enrolled for at least six credit hours to complete the following section prior to the start of classes.

Please review the enclosed information regarding Meningitis, review the options below, check the appropriate boxes, and sign.

I have/My child has: *(check one)*

☐ Had the meningococcal meningitis immunization within the past 10 years.

Date Received: _____/_____/_____

Note: *If you/your child received the meningococcal vaccine available before February 2005, called Menomune, please note this vaccination protection lasts for approximately 3 to 5 years. Revaccination with the new conjugate vaccine called Menactra, should be considered within 3 to 5 years after receiving Menomune.*

☐ Read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving this vaccine. I have decided that I (my child) will **NOT** obtain immunization against meningococcal meningitis disease.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

CONSENT TO TREAT MINORS (ONLY FOR STUDENTS UNDER 18)

The relationship between a student and the College is confidential. Medical information will only be released when and if prescribed by law and/or at the written request of the student or guardian.

PARENTAL PERMISSION: The law requires that parental permission be obtained for treatment and for vaccinations (as recommended by The Centers for Disease Control and New York State Department of Health) for persons less than 18 years of age (minors). This consent form should be signed by parents so that such treatment/vaccination may be promptly carried out and unnecessary delays be avoided.

Statement of Consent: I give permission to the Student Health Office for vaccinations and treatment procedures as may be deemed medically necessary for my son/daughter named above.

Name of Parent/Guardian (Print): _____ Relationship: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian contact information (phone# and/or email): _____

Return To:
PrattMWP College of Art and Design
Student Life Office
310 Genesee Street
Utica, NY 13502
Fax: (315)797-9349