PHYSICAL & IMMUNIZATION FORM

- Complete page 1, then give to your healthcare provider to complete page 2 and 3.
- This form must be completed **and** signed by a MD/DO, NP or PA.
- For Division 1 athletes, physical examination must be done within 6 months for sports participation.
- Records must be in English. Immunization format must be Month/Day/Year (MM/DD/YY).

Incomplete or overdue forms will result in registration withdrawal and prevent sports participation.

- **If attending in fall**, the form is due **July 31**
- **If attending in spring**, the form is due **January 1**

Phone: 716.888.2610
Fax: 716.888.3217
Email: health@canisius.edu

THIS SECTION TO BE COMPLETED BY STUDENT OR PARENT/GUARDIAN

LAST NAME	FIRST NAME	PREFERRED NAME	COLLEGE ID

DATE OF BIRTH (MM/DD/YY)	SEX ASSIGNED AT BIRTH	GENDER	PREFERRED PRONOUNS

EMAIL ADDRESS	PHONE NUMBER	CITIZENSHIP

EMERGENCY CONTACT (for medical emergencies)

EMERGENCY CONTACT - NAME/RELATIONSHIP	HOME PHONE	CELL PHONE	WORK PHONE

CONSENT TO TREAT, ATTESTATION, AUTHORIZATIONS

Without signature Student Health can not treat this student. Parent or Guardian must sign for student under 18 years of age. I authorize the Canisius College Student Health Center to provide care and treatment to me (my child/legal ward) as deemed appropriate. I agree to the provision of care either by in person physical examination or remotely via telemedicine. This care includes but is not limited to routine, urgent, emergency care, medication, immunization, diagnostic studies and referrals to hospitals, clinics and/or medical specialists deemed necessary by the college's medical and/or nursing staff. In the event of a life threatening emergency or serious illness/injury of which the Student Health Center is aware, I authorize the Student Health Center or college designee to notify my emergency contact. I verify that all medical and psychological information I have provided is complete and accurate. I will notify the Student Health Center hereafter of any changes in my health that occur while a student at Canisius College. I authorize Student Health to communicate with me using my secure health portal, myCanisiusHealth. This communication may include but is not limited to lab results, clinical notes and additional medical recommendations for my ongoing care and treatment each semester I am a registered student at the college. Access to myCanisiusHealth is limited to the current semester enrolled. I also attest that I understand the limitations and possible risk of telemedicine visits.

SIGNATURE OF STUDENT (REQUIRED)	**DATE (MM/DD/YY)**

PARENT/GUARDIAN SIGNATURE (REQUIRED FOR STUDENTS UNDER 18)	**DATE (MM/DD/YY)**

MEDICAL HISTORY

PAST MEDICAL HISTORY: _____

PAST SURGICAL HISTORY: _____

ALLERGIES

_____
_____
_____
_____
_____
_____

MEDICATIONS
(INCLUDING SUPPLEMENTS)

_____
_____
_____
_____
_____
_____

SOCIAL HISTORY

Do you smoke?
If yes, how much?

_____

Do you drink alcohol?
If yes, how much?

_____

FAMILY HISTORY
(BLOOD RELATIVES)

_____
_____
_____
_____
_____
_____

IMMUNIZATIONS

HEALTHCARE PROVIDERS, PLEASE COMPLETE, SIGN AND DATE PAGES 2 & 3

NAME OF STUDENT | DATE OF BIRTH (MM/DD/YYYY) | COLLEGE ID #

REQUIRED VACCINES FOR ALL STUDENTS. Please submit dates in MM/DD/YY format.

MMR (MEASLES, MUMPS, RUBELLA)

If born after 1956, two doses of MMR vaccine are required. Dose #1 administered on or after the 1st birthday. Dose #2 administered at least 28 days after the first dose

-OR-

Laboratory confirmation of immunity.
Lab results with reference range must be attached

Dose #1 ____ /____ /____ (MM / DD / YY)

Dose #2 ____ /____ /____ (MM / DD / YY)

-OR-

Date of titer confirming immunity ____ /____ /____ (MM / DD / YY)
Attach lab report (required)

MENINGOCOCCAL VACCINE

One dose of ACWY within the last 5 years

-OR-

MENINGOCOCCAL SEROGROUP B

Completed series of 2 or 3 doses within the past 5 years

-OR-

MENINGITIS WAIVER

Student to read and sign page 4

Date administered ____ /____ /____ (MM / DD / YY)

Specify Brand: ☐ Menveo ☐ Menactra ☐ Other: _____

Bexsero	Trumenba
Dose #1 ____ /____ /____ (MM / DD / YY)	Dose #1 ____ /____ /____ (MM / DD / YY)
Dose #2 ____ /____ /____ (MM / DD / YY)	Dose #2 ____ /____ /____ (MM / DD / YY)
	Dose #3 ____ /____ /____ (MM / DD / YY)

RECOMMENDED VACCINES FOR ALL STUDENTS.

COVID-19	Completion of primary series and bivalent booster are strongly recommended	Dose #1 ____ /____ /____ (MM / DD / YY) _____ Brand/Manufacturer Dose #2 ____ /____ /____ (MM / DD / YY) _____ Brand/Manufacturer Booster ____ /____ /____ (MM / DD / YY) _____ Brand/Manufacturer	
POLIO	Date primary series completed	____ /____ /____ (MM / DD / YY)	
VARICELLA	Two doses -OR- Serology	Dose #1 ____ /____ /____ (MM / DD / YY) Dose #2 ____ /____ /____ (MM / DD / YY)	Titer Date ____ /____ /____ (MM / DD / YY) ***Attach lab report (required)***
TDAP/TD	One booster within the last 10 years	____ /____ /____ (MM / DD / YY)	
HEPATITIS B	Series of three doses	Dose #1 ____ /____ /____ (MM / DD / YY) Dose #2 ____ /____ /____ (MM / DD / YY) Dose #3 ____ /____ /____ (MM / DD / YY)	
HEPATITIS A	Series of two doses	Dose #1 ____ /____ /____ (MM / DD / YY)	Dose #2 ____ /____ /____ (MM / DD / YY)
HPV	Two or three doses based on 2016 ACIP guidelines	Dose #1 ____ /____ /____ (MM / DD / YY) Dose #2 ____ /____ /____ (MM / DD / YY) Dose #3 ____ /____ /____ (MM / DD / YY)	

HEALTH CARE PROVIDER SIGNATURE | **HEALTH CARE PROVIDER PRINTED NAME / STAMP**

ADDRESS | **PHONE**

PHYSICAL EXAMINATION

NAME _____ DATE OF BIRTH (MM/DD/YYYY) _____

HEIGHT _____ WEIGHT _____ BLOOD PRESSURE _____ PULSE _____

☐ Check if exam is entirely normal List any abnormal exam findings: _____

TUBERCULOSIS (TB) SCREEN Required for all students.

*If TB screen is positive, TB testing must be completed in the United States.

1. Does the student have signs or symptoms of active TB disease?

☐ **YES** (go to TB Test) ☐ **NO** (go to question 2)

2. Is the student a member of a high risk group, or from a high risk country?

☐ **YES** (go to TB Test) ☐ **NO** (**STOP** No further screening needed)

PPD (MANTOUX TUBERCULIN SKIN TEST)

Date placed: _____/_____/_____ (MM/DD/YY)

Date read: _____/_____/_____ (MM/DD/YY)

Result: _____ mm of induration

Interpretation:

☐ Negative ☐ Positive (Chest X-ray required)

TB SKIN TEST -OR- TB BLOOD TEST

QUANTIFERON-GOLD OR T-SPOT

Date Tested: _____ / _____ /_____ (MM/DD/YY)

Result:
☐ Negative
☐ Indeterminate/Borderline
☐ Positive (Chest X-Ray required)

Attached lab report is required.

CHEST X-RAY: REQUIRED ONLY IF POSITIVE TST OR IGRA

Chest X-Ray Date: _____/_____/_____ (MM/DD/YY) ***Attach signed radiology report. Must be in English.***

☐ Normal ☐ Abnormal (explain) _____

If positive TB Test and negative chest xray, was the student counseled on treatment for LTBI? ☐YES ☐NO

If TB treatment was completed, document the dates of treatment, name and dose of medication.
Medication _____ Treatment dates and duration _____

*D1 ATHLETES- SICKLE CELL SCREEN REQUIRED

Sickle Cell Screen Date: _____/_____/_____ (MM/DD/YY) Result: ☐Positive ☐Negative

ACTIVITY CLEARANCE

Is this student cleared for full physical activity, including participation in intramural, club or intercollegiate sports and able to meet the physical and emotional demands of college life, including studying abroad?

☐ **YES** - Full activity and fit for college ☐ **NO** - Limited activity Reason:_____

Additional Comments/Recommendations:_____

I have reviewed the medical history and immunizations, conducted the TB screen and examined the student noted above. The information on this physical form is accurate, full and complete to the best of my knowledge.

HEALTH CARE PROVIDER SIGNATURE **HEALTH CARE PROVIDER PRINTED NAME / STAMP** **DATE OF EXAM**

ADDRESS **PHONE**

MENINGOCOCCAL DISEASE RESPONSE FORM

PLEASE READ AND COMPLETE BELOW

Canisius

LAST NAME FIRST NAME MIDDLE INITIAL COLLEGE ID / MEDICAT ID DATE OF BIRTH (MM/DD/YYYY)

WHAT IS MENINGOCOCCAL DISEASE?
Meningococcal disease is caused by bacteria called Neisseria meningitidis. It can lead to serious blood infections. When the linings of the brain and spinal cord become inflamed, it is called meningitis. The disease strikes quickly and can have serious complications, including death.

WHO GETS MENINGOCOCCAL DISEASE?
Anyone can get meningococcal disease. Some people are at higher risk. This disease occurs more often in people who are:
- Teenagers or young adults
- Infants younger than one year of age
- Living in crowded settings like college dormitories or military barracks
- Traveling to areas outside of the United States, such as the "meningitis belt" in Africa
- Living with a damaged spleen or no spleen
- Being treated with Soliris or, who have complement component deficiency (an inherited immune disorder)
- Exposed during an outbreak
- Working with meningococcal bacteria in a laboratory

WHAT ARE THE SYMPTOMS?
Symptoms appear suddenly-usually 3 to 4 days after a person is infected. It can take up to 10 days to develop symptoms. Symptoms may include:
- A sudden high fever
- Headache
- Stiff neck (meningitis)
- Nausea and vomiting
- Red-purple skin rash
- Weakness and feeling very ill
- Eyes sensitive to light

HOW DOES MENINGOCOCCAL DISEASE SPREAD?
It spreads from person-to-person by coughing or coming into close or lengthy contact with someone who is sick or who carries the bacteria. Contact includes kissing, sharing drinks, or living together. Up to one in 10 people carry meningococcal bacteria in their nose or throat without getting sick.

WHAT ARE THE COMPLICATIONS?
Ten to 15 percent of those who get meningococcal disease die. Among survivors, as many as one in five will have permanent disabilities. Complications include:
- Hearing loss
- Brain damage
- Kidney damage
- Limb amputations

WHAT IS THE TREATMENT FOR MENINGOCOCCAL DISEASE?
Early diagnosis of meningococcal disease is very important. If it is caught early, meningococcal disease can be treated with antibiotics. But, sometimes the infection has caused too much damage for antibiotics to prevent death or serious long-term problems. Most people need to be cared for in a hospital due to serious, life-threatening infections.

WHAT SHOULD I DO IF I OR SOMEONE I LOVE IS EXPOSED?
If you are in close contact with a person with meningococcal disease, talk with your health care provider about the risk to you and your family. They can prescribe an antibiotic to prevent the disease.

WHAT IS THE BEST WAY TO PREVENT MENINGOCOCCAL DISEASE?
The single best way to prevent this disease is to be vaccinated. Vaccines are available for people 6 weeks of age and older. Various vaccines offer protection against the five major strains of bacteria that cause meningococcal disease:
- All teenagers should receive two doses of vaccine against strains A, C, W and Y. The first dose is at 11 to 12 years of age, and the second dose (booster) at age 16.
  - It is very important that students receive the booster dose at age 16 in order to protect them through the years when they are at greatest risk of meningococcal disease.
  - Talk to your health care provider if you have not received two doses of vaccine against meningococcal strains A, C, W and Y.
- College students can also be vaccinated against the "B" strain. Talk to your health care provider about whether they recommend the vaccine against the "B" strain.

Others who should receive the vaccine include:
- Infants, children and adults with certain medical conditions
- First-year college students through 21 years of age living in residential housing
- People exposed during an outbreak
- Travelers to the "meningitis belt" of Sub-Saharan Africa
- Military recruits

IS THERE AN INCREASED RISK FOR MENINGOCOCCAL DISEASE IF I TRAVEL?
Meningococcal disease and outbreaks occur in the United States and around the world. The disease is more common in the "meningitis belt" of sub-Saharan Africa. The risk is highest in people who visit these countries and who have prolonged contact with local populations during an epidemic. To reduce your risk of illness, wash your hands often, maintain healthy habits, such as, getting plenty of rest and try not to come into contact with people who are sick.

HOW DO I GET MORE INFORMATION ABOUT MENINGOCOCCAL DISEASE AND VACCINATION?
Learn more about meningococcal disease at **www.cdc.gov/meningococcal/** or **www.health.ny.gov/.**

STUDENT RESPONSE

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

SIGNATURE OF STUDENT OR PARENT/GUARDIAN OF MINOR STUDENT **DATE (MM/DD/YY)**