

Consent for Medical Care:

All registered students AND parent/guardian of students under 18 years of age MUST sign. I hereby give permission to the SUNY Oneonta medical/nursing staff to examine and treat (Student's name) _____ for all medical problems/injuries while he/she is at SUNY Oneonta. In the event of time restraints, or that I cannot be reached, I hereby give permission for the Health & Wellness Center staff to secure consultative care that may include hospitalization, anesthesia, surgery and/or other medical treatment. I understand that I have the right to revoke this consent at any time.

_____ AND _____
 Student signature/Date Parent/guardian signature of a student under 18 years of age/Date

NCAA Athletes: I hereby give permission to both the SUNY Oneonta Health Services and Athletics to share pertinent health information between each other for participation in intercollegiate sports.

Student signature: _____ Date: _____

Part II - Health History (to be filled out by student)

Last Name: _____ First Name: _____ ID# _____

Please indicate if you have ever had/have the following:

Illness	Yes	No	Illness	Yes	No
Cancer			Seizures/Convulsions		
Stomach/Intestinal Problems			Chronic Cough		
Thyroid Problem			Alcohol/Drug Abuse/Smoke		
Chicken Pox			Heart Murmur/Disease/Clotting Disorder		
Anemia			Joint Disease/Injury		
Eye Trouble			Jaundice/Hepatitis		
Asthma/Hayfever			Tuberculosis		
Diagnosed Depression/Anxiety/Mood Disorder/Counseling			Eating Disorder		
High/Low Blood Pressure			Recent Weight Loss/Gain		
Sexually Transmitted Infection			Dizziness/Fainting		
Diabetes			Weakness/Paralysis		
Recurrent Headaches			Kidney Problems/Urinary Problems		
Head Injury/Unconsciousness					

List any surgeries: _____

List current medications: _____

Allergies to: Food Medication Other If circled, please explain: _____

Part III - Physical Examination - Mandatory for NCAA athletes and international students/Optional for non-NCAA athletes Athletes - physical must be done within 6 months of practice start date

Date of Exam: _____

1. Height _____ 2. Weight _____ 5. Vision Right 20/ Corr. 20/
 3. Blood Pressure ____/____ 4. Pulse _____ Left 20/ Corr. 20/

Describe any abnormalities in the space below:

	Normal	Abnormal		Normal	Abnormal
1 ENT			6 Musculoskeletal		
2 Respiratory			7 Metabolic/Endocrine		
3 Cardiovascular			8 Neuropsychiatric		
4 Gastrointestinal			9 Skin		
5 Genito-urinary			10 Other		

Recommended Vaccines	Dates
HPV Vaccine	1. _____ 2. _____ 3. _____
Hepatitis A	1. _____ 2. _____ 3. _____
Hepatitis B	1. _____ 2. _____ 3. _____
Varicella Vaccine	1. _____ 2. _____
Chicken Pox Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tetanus (within 10 years)	
Tetanus Diphtheria Acellular Pertussis (TDAP) (date series completed and last booster)	1. _____ 2. _____
Polio - date series completed	
PPD Mantoux (if test is positive, chest x-ray is required) - see below for international students	Date given _____ Date read _____ Result _____ mm
BCG	Date _____ NA
Chest X-Ray (if positive PPD, attach report)	Date _____ Result _____

Clearance for physical activity:

NCAA Athletics Yes No

Intramural/ Club Sports Yes No

Mandatory Provider Signature

Signature of Examining Practitioner _____

Name _____

Address _____

Telephone No. (including area code) (____) _____

Practitioner stamp: _____

International students MUST have their Tuberculosis screening done at the Student Health Center when they arrive at SUNY Oneonta.