

THE SAGE COLLEGES

Report of Medical History and Physical and Immunizations
 Required for all FULL TIME Sage College Students.
 This form must be completed and on file at the Health
 Center NO LATER than AUGUST 1ST for the fall semester
 and JANUARY 1ST for the spring semester.

FOR ADMINISTRATIVE PURPOSES ONLY	
Semester: _____	Fall
_____	Spring
_____	Summer
Entering Year: _____	
Reviewed By: _____	
Date: _____	

RETURN COMPLETED FORM TO:

Russell Sage College Wellness Center
Attn: Immunization Coordinator
45 Ferry Street
Kellas Hall
Troy, New York 12180
(518) 244-2261, Fax (518) 244-2262

Sage College of Albany Wellness Center
Attn: Immunization Coordinator
140 New Scotland Ave
Kahl Campus Center – lower level
Albany, New York 12208
(518) 292-1917, Fax (518) 292-1918

To ensure that this form is complete:

1. Fill out **side 1 and 2** before going to your Health Care Provider.
2. Bring this form to your Provider for a **physical exam**.
3. Have your Health Care Provider fill in the **Examination and Immunization** information on this form.
4. Be sure that this form is signed by your Health Care Provider (**Pages 2,3 & 4**).
5. SIGN the authorization for treatment form on **Page 3 yourself**.
6. Return **COMPLETED** form to the appropriate Wellness Center as listed above prior to registration.

This form must be completed and received before you can register for classes. INFORMATION RECEIVED IS CONFIDENTIAL AND WILL NOT JEOPARDIZE YOUR ACCEPTANCE STATUS OR ACADEMIC STANDING.

Please Print or Type

 Last Name First Name Middle Date of Birth

 Telephone No. () Student ID #

 Home Address (Number and Street) City or Town State Zip Code

 Name and Address of Next of Kin

Type of Insurance Policy: Name of Policy _____

Family Student Other Policy Number _____

MEDICAL HISTORY

A. Please check any condition which you or a close family member has or has had. Indicate the relationship.

	Self		Family		Relationship
	Y	N	Y	N	
Alcoholism					
Breast Disease					
Cancer					
Elevated Cholesterol					
Diabetes					
Genetic or Birth Defect					
Heart Attack					
High Blood Pressure					
Sickle Cell Trait or Disease					
Stroke					
I am adopted Yes ___ No ___					

B. Check Yes or No below if you have ever had any of the following:

	Y	N		Y	N		Y	N
Anemia (Low Iron)			Gallbladder Stones or Disease			Rheumatism or Arthritis		
Asthma			Head Injury w/ Unconsciousness			Scarlet Fever		
Back Problems			Heart Murmur			Severe Weight Gain		
Bronchitis			Hernia			Severe Weight Loss		
Cancer			Infectious Mononucleosis			Sexually Transmitted Disease		
Chicken Pox			Irritable Bowel Disease			Sinus Infection		
Colitis			Jaundice			Skin Disorders		
Depression			Learning Disability			Suicide Attempt		
Diabetes			Liver Disease or Hepatitis			Throat Infections		
Disease/Injury of Joints			Menstrual Irregularities			Thyroid Abnormalities		
Ear Infections			"Nervous" Stomach			Ulcers (Stomach or Duodenal)		
Eating Disorder			Ovarian Cyst			Urinary Tract or Kidney Infections		
Epilepsy/Convulsions/Seizures			Pelvic Infections			Uterine Abnormalities		
Eye Problems			Pneumonia			Vaginal Infections		
Frequent Headaches			Rheumatic Fever			Varicose Veins		

1. List any surgery/operations you've had and dates: _____ Remarks or additional information _____
 _____ (Use additional sheet if necessary)

2. Have you been hospitalized overnight? Yes _____ No _____

Why? _____

3. Do you experience depressions, anxiety, or other emotional problems? Yes _____ No _____

4. Have you received counseling at any time? Yes _____ No _____ Dates _____

For what? _____

Are you currently receiving counseling? Yes _____ No _____ Where _____

For what? _____

5. Please list all medications currently being taken with dosage, frequency and condition for which it is being taken:

Medication	Dosage	Frequency	Condition

6. List ALL ALLERGIES you have:

Medications: _____

Foods: _____

Bees/Insects: Yes _____ No _____ Do you carry an EPI-PEN? Yes _____ No _____

Environmental: _____

7. Tobacco use: Yes _____ No _____ Type/Amount _____

8. Alcohol use: Yes _____ No _____ Amount _____ Drug use? Yes _____ No _____ Type/Amount _____

9. Do you wear glasses? _____ Contacts? _____

Student's Signature

Clinician's Signature
(Acknowledge Review)

Date

REPORT OF PHYSICAL EVALUATION

To the Examining Clinician: Please provide as much information as you can about this patient. Information provided is confidential and will not jeopardize a student's acceptance or academic status. Information is available only to Health Center Staff, unless the student authorizes release of information.

Name: _____ DOB: _____

URINALYSIS

BLOOD WORK (as applicable)

Appearance _____ Glucose _____ Cholesterol _____
Ketones _____ Blood _____ Hemoglobin or Hematocrit _____
pH _____ Protein _____
Leukecytes _____

- 1. Height Ft. _____ In. _____ Wt. Lbs. _____
Temp _____ BP _____ / _____
- 2. Last Exam _____
- 3. Mental Status _____
- 4. General Appearance _____
- 5. Skin _____
Scars _____ Tatoo _____
- 6. Eyes: Vision OD _____ OS _____ (circle one) Corrected/Uncorrected
PERRLA _____ E.O.M. _____ Sclera _____
- 7. Ears: Canals R _____ L _____ TM's _____
- 8. Nose: MM _____ Patency _____
- 9. Mouth & Throat _____ Teeth _____
- 10. Neck _____ Thyroid _____ Trachea _____
- 11. Chest & Lungs _____ Deformities _____
- 12. Breasts _____ Discharge _____
- 13. Heart: Rate _____ Rhythm _____ Murmurs _____
Peripheral Pulses:
Carotid _____ Radial _____ Femoral _____ Dorsalis Pedis _____
- 14. Abdomen _____ Palp. Organs _____
Masses _____ Tenderness _____
- 15. Hernia: Inguinal _____ Abdominal _____
- 16. Ext. Genitalia _____ Rectal _____
- 17. Back: (Scoliosis, Etc.) _____ CVA _____
- 18. Extremities/Joints _____
- 19. Lymph Nodes: Cerv. _____ Ax. _____ Ing. _____
- 20. Neurologic:
a) gait _____ d) sensory _____
b) Romberg _____ e) tremor _____
c) muscle strength/tone _____

Recommendations for physical activity (PE/intramurals): Unlimited Limited Explain : _____

Do you have any recommendations regarding the care of this student? Yes _____ No _____

Is the patient now under treatment for any medical or emotional condition? Yes _____ No _____ If Yes, provide details below:

Clinician's Signature _____ Print Last Name _____

Address _____ Phone _____ Date _____

I DO HEREBY AUTHORIZE THE SAGE COLLEGE TO PROVIDE FIRST AID TREATMENT AND IN CASE OF EMERGENCY, I AUTHORIZE THE TRANSPORTATION INVOLVED AND THE TREATMENT NECESSARY BY A PRACTITIONER AND/OR AT A HOSPITAL. I SHALL ASSUME ANY EXPENSES WHICH ARISE.

SIGNED _____
(Student)

SIGNED _____
(Parent or Guardian if Student is under 18 years of age)