DYOUVILLE

SCHOOL OF PHARMACY

SOP Health Form Checklist for Fall 2020

- Part A (pgs. 3-4) and Part B (pgs. 5-6) should be completed by the student
- Part C (Pg. 7) and Part D (pgs. 8-9) must be completed by a Physician, NP, or PA
    - Physician, NP, or PA must sign and stamp or print their name on page 9

- Attach immunization summary obtained from physician
  ** must have the dates the immunizations were given OR titer results proving immunity, attach titer result documentation. **

1. ***PPD-** 2 step is required for entry in to pharmacy program. The first PPD read date and second PPD administer date must be at least one week apart.
2. ***Meningitis Vaccination Response pg. 8** **Meningitis Vaccines are only good for 5 years**
   ***IF VACCINE IS within 5 years, check the 1st box & immunization** date.
   ***IF VACCINE IS EXPIRED, check the 2nd box.** This form must be signed by the student for either response
3. **MMR**-must have 2 immunizations OR titer proving immunity
4. **Tdap-**must have immunization within 10 years
5. **Hep B**-must have 3 immunizations OR a titer proving immunity
6. **Varicella (Chicken Pox)**-must have 2 immunizations or titer proving immunity

******Student Required Signatures** - you must sign pages 4, 6, 8 and 9.

***Check your form to make sure all the pages are filled out correctly and completed with all signatures.

ALLIED HEALTH STUDENT MEDICAL ASSESSMENT

This form must be completed prior to registration for all School of Pharmacy Fall 2020 Courses

- ✓ **Parts A and B should be completed by the student and Parts C and D should be completed by a physician, NP, or PA.**
- ✓ **Student (or parent / guardian if student under 18 years old) needs to sign the *Authorization for Health Service* on page 4.**
- ✓ **Keep one copy for your records.**
- ✓ **Return all original forms to: D'Youville Health Office, 320 Porter Avenue Buffalo, NY 14201.**

Part A- To be Completed by Student

Personal Information

Last Name First Name MI	Date of Biirth	Social Security Number
	_____ / ______ / 19 _____	_____ / ____ / _______
Permanent Home Address Street ________________________ City_______________ State / Prov. _____ Zip /Post _________		Home Phone Number (_____) ______- _________
Local Address (if known) Street ________________________ City_____________ __ State / Prov. _____ Zip /Post _________		Local Phone Number (if known) (_____) ______- _________
Birth Place	Sex ❑ Male ❑ Female	Cell Phone number (if known) (_____) ______- _________

Emergency Contact Information

Last Name First Name MI	Relationship to Student	Home Phone Number
		(_____) _______- ___________
Home Address Street ________________________ City ________________ State / Prov. ______ Zip /Post ________		Work Phone Number (_____) _______- ___________
		Cell Phone Number (_____) _______- ___________

Health Insurance Information

(Please attach a copy of your health insurance card)

Name of Company and Type of Insurance Coverage			
Group Number	ID Number	Member Number	Other Numbers

** D'Youville has mandated insurance for students who fall under a certain criteria. If you have insurance you will need to go to the website and show proof of insurance coverage in order to waive. If you do not have the required insurance coverage you must enroll and the cost will be added to your tuition bill. If you do not fall under D'Youville's criteria but wish to enroll you may go to the website and do so. Canadian students please contact the health office 716-829-8777.

https://www.haylor.com/college/dyouville-college/

AUTHORIZATION FOR HEALTH SERVICE

1. Permission is hereby granted to the D'Youville College Health Center to administer medical services.

2. Permission is also granted in the event of an emergency to:

    a) Perform emergency procedures and administer medical care;

    b) To refer the student to a duly licensed physician, surgeon, dentist, or recognized hospital;

    c) To grant on my behalf to any such licensed physician, surgeon, dentist, or recognized hospital permission to perform any diagnostic, medical, or surgical treatment deemed appropriate by the College health service, or such physician, surgeon, dentist, or recognized hospital.

The Law requires that before medical or dental services can be performed for a person under 18 years of age, permission must be secured from the parent or guardian. Signing below grants this permission.

Signature of Student ___________________________________ Date ________
(if student over 18 years of age)

Signature of Parent / Guardian ____________________________ Date ________
(if student under 18 years of age)

Part B- To be Completed by Student:

SELF-REPORTED MEDICAL HISTORY

Allergies- Check appropriate response and describe (if necessary) the reaction that occurs.

- ❑ **No Known Allergies**
- ❑ **Medication Allergy** ____
- ❑ **Environmental / Seasonal Allergy** ____
- ❑ **Insect or Bee Allergy** ____
- ❑ **Food Allergy** ____

Current Prescription Medications

- ❑ **I currently do not take any prescription medications.**
- ❑ **I take the following prescription medications:**

Name	**Dosage and Dosing Schedule**
__________________	_________________________________
__________________	_________________________________
__________________	_________________________________

Review of Systems

Please check "yes" if you have had any of following conditions. Explain "yes" answers in the space provided below.

	YES		YES		YES
CARDIAC		**DENTAL**		**EYES / EARS**	
High Blood Pressure		Bleeding Teeth		Color Blindness	
High Cholesterol		Poor Teeth		Wear glasses/contact lenses	
Irregular Heart Rate		Wisdom Teeth Extraction		Eye injury / Disease	
History of Palpitations		**EARS / NOSE / THROAT**		Blindness	
Chest Pain		Hearing Loss /Deafness		Hearing Impaired	
NEUROLOGICAL		Frequent Ear Infections		**GASTROINTESTINAL**	
Migraines/Frequent Headaches		Perforated Eardrum		Stomach Problems / Ulcer	
Dizziness / Fainting		Repeated Nosebleeds		Hepatitis	
Severe Head Injury/ Concussion		Frequent Sinus Infections		Irritable Bowel Problems	
Insomnia		Tonsils/Adenoids Surgery		Gallbladder Problems	
Neuromuscular Disorder		**INFECTIOUS DISEASE**		Hemorrhoid Problems	
Seizures / Epilepsy		Chicken Pox		Appendectomy	
HEMATOLOGIC		Mononucleosis		Hernia	
Anemia / low iron		Meningitis		Colitis	
Sickle Cell Trait/ Disease		Measles / German Measles		**GENITOURINARY**	
Clotting Disorder		Mumps		Freq Urinary Tract Infections	
MENTAL HEALTH		Typhoid Fever		Kidney Stones or Disease	
Anxiety Disorder		Polio		Sexually Transmitted Infection	
Clinical Depression		Whooping Cough		**ENDOCRINE**	
Anorexia / Bulimia		**MUSCULOSKELETAL**		Diabetes	
Suicide Attempt		Arthritis		Sudden weight Change	
RESPIRATORY		Fractures or Dislocations		Thyroid problem/disease	
Asthma		Back / Disc Problems		**WOMEN**	
Chronic Cough		Scoliosis		Menstrual Irregularity	
Bronchitis or Pneumonia		Other Joint Disease		Disabled by Cramps	
HOSPITALIZATION/SURGERIES		Paralysis		Abnormal Pap Smear	
OTHER		Multiple Sclerosis		Pelvic Inflammatory Disease	
Cancer, Cyst, Tumor		Severe Injury		**LIMITATIONS ON ACTIVITIES**	

Describe details for each "yes" and the appropriate date(s). Please use an extra page if space provided is not adequate:

FAMILY HISTORY

Relative	Age	State of Health	Occupation	Age at Death	Cause of Death
Father					
Mother					
Brother(s)					
Sister(s)					
Children					

Have any of your relatives had any of the following?			
	Yes	**No**	**Relationship**
Alcoholism			
Allergies / Asthma			
Anemia / Bleeding Disorder			
Arthritis			
Cancer			
Diabetes			
Emotional / Mental Disease			
Epilepsy / Seizure Disorder			
Heart Disease			
Headaches / Migraines			
High Blood Pressure			
Kidney / Bladder Problems			
Stomach Disorder			
Stroke			
Tuberculosis			

I certify to the best of my knowledge that the information on this form is complete and correct.

Student Name (Please Print) ____

Student Signature ______________________________________ Date ___ / ___ / 20___

Part C- To be Completed by Health Care Provider (Physician, NP, or PA)

PHYSICAL EXAMINATION

<table>
<tr><td colspan="4">Last Name First Name MI</td><td>Date of Birth
_____ / ______ / 19 _____</td></tr>
<tr><td>Ht
Ft_____ In _____</td><td>Wt
Lbs________</td><td>Blood Pressure
S_____ D______</td><td>Pulse
___________</td><td>Sex
❑ Male ❑ Female</td></tr>
<tr><td colspan="4">Vision
With Glasses: Left________ Right _______ Without Glasses: Left _______ Right _______</td><td>Allergies
❑ NKA
❑ Other _________________</td></tr>
</table>

	Normal	Abnormal	Comments
Head, Neck, Face, Scalp, Skin	❑	❑	_______________________________
Ears, Nose & Throat	❑	❑	_______________________________
Oral Cavity	❑	❑	_______________________________
Lungs, Chest	❑	❑	_______________________________
Heart	❑	❑	_______________________________
Abdomen & viscera	❑	❑	_______________________________
Musculoskeletal	❑	❑	_______________________________
Hearing	❑	❑	_______________________________
Other			_______________________________

Physical Limitations (if any): ____

Part D- To be Completed by Health Care Provider (Physician, NP, PA, or DC)

REQUIRED IMMUNIZATIONS

1. Tuberculosis Risk Assessment- Required Annually

PPD	1st PPD Date Given ___________ Date Read ____________ 2nd PPD Date Given ___________ Date Read ____________	Results: Circle one: 1st PPD: Positive ____ Negative _____ 2nd PPD: Positive ____ Negative _____
	If either PPD result is positive, a chest x-ray must be obtained and a copy of the report must be on file in the Health Center. Previous BCG vaccine does not exempt the student from this requirement and a chest x-ray is not an acceptable substitute for a PPD skin test.	If Applicable: Chest X-Ray: Date ______ Results ________________________

2. Meningitis Vaccination Response

Please check one box only and sign below.

I have / my child:

- ❑ **Had the meningococcal meningitis immunization (Menactra™) within the last 5 years. Vaccination Record attached. Date of vaccination: ___________**
- ❑ **Read the meningitis information found on the D'Youville College Web Site under "Health Center" 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 (or my child) will NOT obtain immunization against meningococcal meningitis disease.**

Signature of Student ____ Date ________
(if student over 18 years of age)

Signature of Parent / Guardian _____________________________ ______________ Date ________
(if student under 18 years of age)

3. MMR (Measles, Mumps, Rubella) Students must have received two doses of MMR vaccine OR have serologic immunity to measles, mumps, and rubella. If prior vaccination documentation is not available, then documentation of immune serology for each component of the MMR vaccine is required.

MMR #1 and #2 **OR** **Measles (Rubeola) Titer** **Mumps Titer** **Rubella (German Measles) Titer** **OR** **Measles (Rubeola) vaccine #1 and #2** **Mumps vaccine #1 and #2** **Rubella vaccine #1 only**	Date ____ / ____ / ______ 1st dose MMR; _____/_____/_____ 2nd dose MMR Immunizations after student's first birthday and after 1/1/69 **OR** Date of positive Measles (Rubeola) titer results: ___ / ___ / _________ Date of positive Mums titer results: ___/ ___/ _________ Date of positive Rubella titer results: ___/ ___/ _________ *****Include copies of all titers with this form.** **OR** Date ____ / ____ / ______ Immunizations after student's first birthday and after 1/1/69 Date ____ / ____ / ______ Date ____ / ____ / ______ Immunization after student's first birthday and after 1/1/69 Date ____ / ____ / ______ Date ____ / ____ / ______ Immunization after student's first birthday and after 1/1/69

3. Tdap, Hepatitis B & Varicella Zoster

Tetanus/Diphtheria (Td) Booster within 10 years **OR** **Tetanus/Diphtheria/ Acellular Pertussis (Tdap)**	Date ____ / ____/ ______ Td Booster Note- Per CDC Guidelines, health care personnel with direct patient contact who have not previously received a dose of Tdap, should receive a single dose of Tdap to replace one Td booster dose. Suggested waiting at least 2 years since last Td booster **OR** Date ___ / ____/ ______ Tdap
Hepatitis B Series #1, #2, #3 **OR** **Hepatitis B Titer**	Dates: ____/____/____ 1st dose; ____/____/____ 2nd dose; ____/____/____ 3rd dose **OR** Date of positive hepatitis B titer: ____/____/_____ ****Include copies of all titers with this form**
Varicella Zoster Vaccine #1, #2 **OR** **Varicella Titer**	Date ____ / ____/ ______ 1st dose; ____/____/____ 2nd dose Varicella Zoster Vaccine **OR** Date of positive varicella titer: ____/____/_____ *****Include copies of all titers with this form. Do not list date of chicken pox disease, you must have the titer to prove immunity.**

____

Healthcare Provider Signature Date *Stamp or Printed Provider Name

____

Address (Area Code) Telephone

I am aware & understand that in order to maintain the health & safety of their clients and meet designated health laws, agencies used for clinical and/or field placement experience may require selected information from my health record. I authorized release of Part D (pg 8-9) to said agencies & to the program office. I also concur that the information above, attested to by my physician, is true.

Signature of Student_____________________________________ Date _________

Student Name (Printed) _________________________________