305 North Service Road
Dix Hills, NY 11746-5871
(631) 656-3127
(631) 656-2190 FAX
www.ftc.edu

FIVE TOWNS COLLEGE

Residence Life Office
HEALTH CLEARANCE FORM

This form is REQUIRED for all students residing in the Living/Learning Center. The information requested on this form is for the use of the Residence Life Office and will not be released to anyone without your knowledge and consent except as required by law.

Directions: Complete Part I of this form. Part II must be signed by a licensed physician and returned to the Residence Life Office along with your completed Housing Application.

PART I

NAME _____ SOC. SEC. #_____-_____-_____
Last First M.I.

ADDRESS _____
Street Address Apt#

_____
City ST Zip

HOME PHONE (_____)_____

SEX: Male _____ Female _____

DATE OF BIRTH ____/____/_____

CELL PHONE (____)_____

E-MAIL _____

Emergency Contact:

_____
Name and Relation to Student

(____)_____
Cell Phone

(____)_____
Home Phone

Alternative Contact:

_____
Name and Relation to Student

(____)_____
Cell Phone

(____)_____
Home Phone

This Health Report and Physician's Certificate is the foundation for the student's medical record at Five Towns college. This enables Health Services to appropriately treat a student in the case of an injury or illness, by having knowledge of his/her past medical history. This form also meets the immunization requirements set forth by the NYS Department of Health.

***All information is strictly confidential, and is never given out unless the student signs a written consent. (Section 355 – Education Law)**

Copies of high school immunization records and insurance card may be attached. This form must be turned in with the deposit and the housing application prior to entering the residence halls.

*PLEASE MAKE COPIES OF THIS DOCUMENT AND ANY LAB REPORTS FOR YOUR PERSONAL RECORDS BEFORE SUBMITTING TO US.

Parental consent for medical care of students under 18 years of age:

_____
Parent/Guardian Signature Date

_____
Notary Signature Date Stamp

Personal History: Check if you have had or presently have any of the following.

Alcoholism _____	Heart problems _____	Shortness of breath _____
Allergy (food)_____	Hepatitis/jaundice _____	Skin problem _____
Allergy (environmental)_____	Herpes _____	Speech disorder _____
Anemia _____	Hernia _____	Surgery _____
Asthma _____	High/low blood pressure _____	Thyroid disease _____
Back problems_____	Insomnia _____	Throat/tonsil problems _____
Bronchitis/pneumonia_____	Intestinal/stomach problems_____	Tuberculosis _____
Cancer/tumor/cyst _____	Joint problems _____	Urinary tract infections _____
Chicken pox _____	Kidney disease/stones _____	
Diabetes _____	Lime disease _____	
Ear trouble/hearing loss_____	Malaria _____	
Eating disorder _____	Meningitis _____	
Eye problem _____	Migraines _____	
Fungal disease _____	Mononucleosis _____	
Gallbladder disease _____	Sinus problem _____	
Gum/Dental Disease _____	Rheumatic/scarlet fever _____	
Gynecological problems _____	Seizures/epilepsy _____	
Head injury _____	STI _____	

DRUG ALLERGIES: Please list

_____

_____

Have you consulted or been treated by a psychologist, social worker, psychiatrist, or other counselor?
Yes ____ No _____

Are you taking any medications? Please list

_____

_____

Insurance Information:
Is the student covered by family insurance? Yes _____ No _____

If so, Name Insurance Carrier: _____

Insurance Number _____ Group Number _____

If you have been hospitalized or have any medical problems, give details:

PHYSICAL EXAMINATION

To the examining physician: Please review the students' history on page 2, complete this page and page 4, and fill in your information on the bottom of page 4. Remarkable notations should be supplemented with additional information as appropriate.

PART II

Height _____ Weight _____ Blood Pressure _____ Pulse _____

1. **Skin** _____
2. **Eyes** _____
3. **Ears** _____
4. **Nose/Sinuses** _____
5. **Mouth/Throat/Dental** _____
6. **Neck/thyroid** _____
7. **Heart** _____
8. **Lungs/chest** _____
9. **Breasts** _____
10. **Abdomen** _____
11. **Nervous system** _____
12. **Extremities** _____
13. **Back** _____
14. **Genitourinary system** _____
15. **Emotional/mental status** _____

FOR FEMALES:
Date of last gynecological exam _____

Pap result _____ N/A _____

Vision
Glasses Yes _____ No _____
Contacts Yes _____ No _____
Eye Glass Prescription _____

LAB WORK (required)
Hemoglobin or hematocrit _____
(Numerical value)

Urinalysis (required)
Albumin _____
Glucose _____

Mantoux test for TB (within 1 year-required)
Date of test_____
Date of reading _____
Neg____ Pos____ MM duration_____

If MANTOUX test is POSITIVE:
Chest X-Ray report:
Date _____
Neg _____ Pos _____

If recent converter or chest x-ray positive, explain treatment: _____
_____
_____

Please list all allergies _____

Recommendations for physical activity: Unlimited _____ Limited _____ (explain below)
_____ Recommendations regarding care of this student (explain below)
_____ Student now under treatment for medical or emotional condition (explain below)

Please comment on any abnormal condition the student has had or is being treated for:

IMMUNIZATION REQUIREMENTS

New York State law requires all students born on or after January 1, 1957 who are attending an institution of higher education to show proof of *two doses of live measles* vaccine given at least one month apart twelve months of age, and *one dose each of live mumps and live rubella* vaccine given after twelve months of age. In lieu of immunization dates, the physician may provide a date of disease for *measles and mumps only*; history of *rubella* disease is not acceptable. Students may also choose to have blood tests called *titers*, which will show actual levels of immunity to each of the three diseases. If titers are drawn, students *must* attach copies of *actual laboratory reports* to this record. *(Nursing, Dental Hygiene, and Medical Laboratory Technology students MUST have titers drawn. See below for further information.)*

MANDATORY

_____ Measles #1 (must be after your first birthday and after 1968)
MM/DD/YY

_____ Measles #2 (must be at least 30 days after first shot)
MM/DD/YY

OR Date of Measles Disease _____
OR Date of Measles Titer _____ (attach copy lab report)

_____ Mumps (must be after your first birthday)
MM/DD/YY

OR Date of Mumps Disease _____
OR Date of Mumps Titer _____ (attach copy lab report)

_____ Rubella (must be after your first birthday)
MM/DD/YY

OR Date of Rubella Titer _____ (attach copy lab report)

OR

#1 _____ #2_____ Combined Measles, Mumps, Rubella
MM/DD/YY MM/DD/YY

_____ Diphtheria-Tetanus (required-must be within **10** years)
MM/DD/YY

ALSO *REQUIRED FOR RESIDENT STUDENTS*, BUT STRONGLY RECOMMENDED FOR COMMUTER STUDENTS, AS WELL:

_____ Meningitis
MM/DD/YY

ALSO STRONGLY RECOMMENDED:

_____ Hepatitis B # 1 **_____** Hepatitis B # 2 **_____** Hepatitis B #3
MM/DD/YY MM/DD/YY MM/DD/YY

****REMINDER – COPIES OF LAB REPORTS FOR ALL TITERS *MUST* BE ATTACHED.**

Provider's Signature _____
Address _____
_____
Phone(_____)_____FAX_____
Print last name _____
Date _____

Return this form to:
Residence Life Office
Five Towns College
305 N. Service Rd.
Dix Hills, NY 11746