Precollege Immersion Program
Medical Information

Return by May 15, 2024

GENERAL INFORMATION *All information is required, and entries must be written in English. Please print*

Last Name _____ First Name _____ MI_____

Preferred Name_____ DOB _____

Home Address _____

Home Phone (_____)_____-_____Cell Phone (_____)_____- _____

Email_____Guardian's Email _____

EMERGENCY CONTACT (PARENT/GUARDIAN)

1. Name_____Relationship_____Phone (_____)_____- _____

2. Name_____Relationship_____Phone (_____)_____- _____

Please provide the name and contact information of the individual who can travel to Pace University's NYC campus in case of anemergency (if different than one or both student's guardian(s) listed above).

1. Name_____Relationship_____Phone (_____)_____ - _____

_____Please check here if the student's guardian(s) will be out of the United States in part or for the entirety of the Program.

HEALTH INSURANCE INFORMATION*

Cardholder_____Relationship _____

Insurance Company_____Group No. _____

Policy No._____Member ID. No. _____

Please provide a copy of the front and back of the insurance card and pharmacy prescription card along with this completed form.

Name of Primary Healthcare Provider_____

Phone (_____)_____-_____Fax (_____)_____- _____

Address _____

Note: University faculty and staff cannot administer medications to any student. The student should be capable of self-administering the medication(s) or schedule the dose for before arrival to or after departure from the Program.

CONSENT FOR MEDICAL TREATMENT OF MINORS (Students Under the Age of 18)

To provide medical evaluation or treatment to minors, permission is necessary by law. All students under the age of 18 years old require a parent's or guardian's signature submitted to the Health Services Center for medical treatment consent.

I hereby grant permission for medical evaluation, treatment, and hospitalization in case of accident or illness for my minor child/legal ward. I also give permission for the release of information concerning my student's medicalcondition to other responsible University officials when necessary or to outside agencies for treatment on an as-needed basis.

Name_____ Signature_____Date _____

Last Name_____ First Name_____ M_____

SECTION 1: MEDICAL HISTORY (To be Completed by Parent/Guardian)

Drug Allergies _____

Food Allergies/Intolerance _____

Other Dietary Restrictions/Needs (e.g. vegan, kosher)_____

Student Requires EpiPen?_____YES_____NO Student Trained in Use?_____N/A_____YES_____NO

Medications ***(Please Include ALL Prescription Medications and Over-the-Counter Medications Taken Daily)*** _____

_____

Past Medical History _____

_____

Family Medical History _____

_____

Travelled Out of the United States in the Last 12 Months?_____Yes_____No

SECTION 2: HEALTHCARE PROVIDER'S EXAMINATION (To be Completed by Provider ONLY)

Height _____ Weight _____ BMI _____ Blood Pressure _____ Heart Rate _____

Vision R_____L_____(Corrected/Uncorrected) Hearing_____(Whisper Acceptable)

SYSTEM	SATISFACTORY	UNSATISFACTORY	DETAILS IF UNSATISFACTORY
HEENT			
Respiratory			
Cardiovascular			
Abdominal			
Genitourinary			
Musculoskeletal			
Skin			
Neurovascular			

Cleared for Physical Activities?_____Yes_____No *If no, please explain. _____

SECTION 3: TUBERCULOSIS TEST *(MANDATORY for International)*

Tuberculosis testing is mandatory for all international students. For international students or those who may have received the BCG vaccine, the T-Spot.TB(PREFERRED) or QuantiFERON blood test is required.

TST (PPD): Date Placed _____ R L Forearm (Circle One) Date Read _____ Result (in MM)* _____

PPD Test Result:____POSITIVE_____NEGATIVE (Circle/Check One)

T-Spot.TB/QuantiFERON Result*:_____(Must Include Copy of Lab Test with Completed Form)

**All positive tests require a chest x-ray within the last five years. A copy of the x-ray results must be included.*

Section 4: Measles, Mumps, and Rubella

VACCINATION DATES: Two Measles vaccinations, one Mumps vaccination, and one Rubella vaccination must have been given **after the student's first birthday.** Please have your health care provider indicate the dates appropriately and certify the form below:

MMR Dose #1:__/___/____ Measles Dose #1: ___/___/___ Rubella Dose #1:___/___/_____

MMR Dose #2:__/___/____ Measles Dose #2: ___/___/___ Rubella Dose #2:__/___/_____

MEDICAL HISTORY: If you have history of contracting either Measles or Mumps disease, please have your health care provider indicate the date(s) appropriately and certify the form below:

Rubella Disease: ___/___/___ Measles Disease:_____/___/____ Mumps Disease:___/____/____

EXEMPTION FROM MEASLES, MUMPS, and RUBELLA VACCINATION (student must legibly check the applicable box):

1) Birth Exception (born prior to January 1, 1957): ☐
2) Medical Exception (circle either **Temporary** or **Permanent**, submit medical documentation): ☐
3) Religious Exception (student with deeply held aversions to receiving vaccinations for religious reasons must submit a formal, signed and dated original statement, indicating such): ☐

Section 5: Meningitis

*This part is not optional, **all students must** fill this part out. You must check **ONE of the TWO** boxes and **MUST SIGN BELOW** to be compliancewith **NYSDOH Public Health Law 2167.** If the fist box is chosen, **a valid date** must be indicated. For students under the age of 18, signature of parent or guardian is also required.*

☐ I have had the meningococcal immunization **within the past 5 years of my first date of enrollment** at Pace University. The date of the shot was_____/_____/_____

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

Section 6: COVID (Optional)

VACCINATION DATES:

☐ Pfizer BioNTech

Dose #1:_____/___/_____Dose #2:_____/___/____ Booster:_____/___/____

☐ Moderna

Dose #1:_____/___/____ Dose # 2_____/___/____ Booster:_____/___/____

☐ Johnson & Johnson

Dose #1:_____/___/____ Booster: /_____/___

☐ Other: _____ Dose #1:____/____/____ Dose #2_____/____/____ Booster: _____/___/___

EXEMPTION (student must legibly check the applicable box):

1) Medical Exception (submit medical documentation): ☐
2) Religious Exception (student with deeply held aversions to receiving vaccinations for religious reasons must submit a formal, signed and dated original statement, indicating such): ☐

Healthcare Provider's Name_____Date of Exam _____

Signature_____License No.*_____Phone _____

STAMP HERE.

This form will NOT be accepted without the healthcare provider's signature and stamp or license number if no stamp is available.
p or license number if no stamp is available.