HOBART AND WILLIAM SMITH COLLEGES

Hubbs Health Center
119 St. Clair St., Geneva, NY 14456
E-mail: Hubbs@hws.edu Phone: 315-781-3600 Fax: 315-781-3802

Physical Examination Form *(physical must be completed within 1 year of admission)*

Name: _____ DOB: _____ Date of Exam: _____
Last First mm/dd/yyyy mm/dd/yyyy

Height: _____(inches) Weight: _____(lbs) Blood Pressure: _____/_____ Pulse: _____

Vision: with corrective lenses Yes_____ No _____ OD _____ OS _____

Check each item in the proper column. (List NE if not evaluated) List any abnormal findings below.

	Normal	Abnormal		Normal	Abnormal
Head, face, scalp			Abdomen		
Eyes			Hernia		
Ophthalmoscopy			Anus and rectum		
Nose			G-U system		
Ears and hearing			Upper Extremities		
Mouth, teeth and gingiva			Lower Extremities		
Throat			Musculoskeletal and spine		
Neck			Skin/lymphatic		
Thyroid			Neurologic		
Chest and lungs			Pelvic exam		
Breasts			Testicular exam		
Heart			Sickle Cell Testing for 1st year athletes only		
Vascular System					

Please explain any abnormal findings: _____
_____
_____
_____

Any diagnoses of food or medication allergies: _____
_____
_____

Will treatment for chronic ailment be required? If so please list with required medication: _____
_____
_____

At present, do you believe the student will need, or would desire to consult a psychiatrist, psychologist or a member of the medical staff while at college? If so explain: _____
_____
_____

I have examined this patient thoroughly. I find them physically and mentally capable to participate in all intercollegiate sports. This includes all collision, contact, and/or non-contact sports. Yes: ____ No: ____ The following restrictions regarding the patient's participation include:

_____
_____

Physician's (MD/DO) Name: (please print) _____
Physician's (MD/DO) Address: _____
Physician's (MD/DO) Signature: _____
Student Name: _____Date of Birth_____/_____/_____

Athletes Only:

In accordance with NCAA requirements, all new Hobart and William Smith student-athletes are required to undergo a pre-participation physical examination **within 6 months** prior to their first date of participation. **It is required that this physical examination be completed by a physician licensed as a MD or DO**. Physicals completed by a physician's assistant or nurse practitioner are invalid and will not be accepted. It is required that you take a copy of this form with you to be completed by you physician. This form must be completed in its entirety and signed by your physician to be valid. Physical examinations performed by a parent/guardian will not be accepted. **Verification of sickle cell trait status is required.**

IMMUNIZATION RECORD: Immunization record to be filled out and signed by a health care provider not a parent**. *All students born on or after January 1, 1957 must include documented proof of immunity to measles, mumps, and rubella as required by New York State Public Health Law 2165. Students must also comply with New York State Public Health Law 2167 which requires students to either have one dose of Meningococcal A,C,W,Y within 5 years or complete a 2 0r 3 dose series of Meningitis B, or sign a Meningitis waiver.***

. Immunization records may also be accepted from previous high schools, colleges, the military or **other official sources. Students who are not compliant will be suspended from Hobart and William Smith Colleges 30 days after classes start and will be** reinstated only when proper documentation has been received at the Health Center.

MMR *(required)* Vaccination or serology

Dose 1 ___/___/___ (Dose 1 given at age 12-15 months or later) Dose 2 ___/___/___ (Dose 2 given at least 28 days after the first dose)

OR

Serology Measles ___/___/___ Result _____: Mumps ___/___/___ Result _____: Rubella ___/___/___/ Result _____

(MUST INCLUDE LAB REPORTS)

MENINGOCOCCAL A,C,W,Y : A meningococcal meningitis vaccine within the last 5 years.

Date ___/___/___ _____Menactra or _____Menveo (Please indicate which vaccine given)

MENINGOCOCCAL B : A meningococcal meningitis vaccine within the last 5 years.

Dose 1 ___/___/___ Dose 2 ___/___/___

Other Vaccines

Vaccine	Guidelines	Dates Administered
Tetanus-Diphtheria-Pertussis	Primary series with booster in last 10 years REQUIRED	1. ___/___/___ 2. ___/___/___ 3. ___/___/___ 4. ___/___/___ Booster: TD ___/___/___ TDAP _____/___
Polio (IPV, OPV)	Primary series REQUIRED	1. ___/___/___ 2. ___/___/___ 3. ___/___/___ Booster ___/___/___ ___/___/___
Varicella	If no documented history of disease, two dose	1. ___/___/___ 2. ___/___/___ History of disease ___/___/___ or Documentation of Positive Titer ___/___/___
Hep A	Recommended two dose series	1. ___/___/___ 2. ___/___/___
Hep B	Recommended three dose series	1. ___/___/___ 2. ___/___/___ 3. ___/___/___

***TUBERCULOSIS RISK ASSESSMENT*: Please check one _____ LOW RISK _____ HIGH RISK (SEE BELOW)**
If a student is high risk for exposure, documentation of a Tuberculin Skin Test (Mantoux) OR a Quantiferon blood test is required WITHIN SIX (6) MONTHS prior to arrival at Hobart and William Smith Colleges. This includes ALL INTERNATIONAL STUDENTS FROM AFRICA, ASIA, LATIN AMERICA AND EASTERN EUROPE. High risk is additionally defined as prior contact with TB, having traveled to any of the above named regions in the last 5 years, having lived or worked in a nursing home, prison, mental health institution, homeless or HIV setting or having a compromised immune system function (history of HIV infection, immune suppressing medication, chemotherapy, chronic kidney failure, diabetes, injection drug use, etc.).

Mantoux (PPD) placed: ___/___/___ Read: ___/___/___ Results _____ mm.induration
If >10mm induration, chest x-ray is required. Date: ___/___/___ Results _____
(Copy of Chest X-ray report required)

Quantiferon IGRA Date: ___/___/___ (please specify) ____ QFT-G ____ QFT-GIT ____ T-SPOT Result: ___ NEG ___ POS
If positive, chest x-ray is required. Date of chest x-ray ___/___/___ Results _____
Note any prophylactic treatment provided with the date initiated _____
(Copy of Chest X-ray report and lab results required)

Health Care Provider Signature _____ Date ___/___/___

Printed Name _____ Phone: (____)_____ Fax: (___)_____

Address _____ City _____ State _____ Zip _____

Please return completed form to the Hubbs Health Center by July 12, 2024. Forms can be e-mailed to hubbs@hws.edu.

HOBART AND WILLIAM SMITH COLLEGES

MENINGOCOCCAL VACCINATION RESPONSE FORM

New York State Public Health Law requires that all college and university students enrolled for at least six (6) semester hours or the equivalent per semester, or at least four (4) semester hours per quarter, complete and return the following form to Hobart and William Smith Colleges, Hubbs Health Center.

Check ONE box and sign below:

I have (for students under the age of 18: My child has):

☐ had meningococcal immunization within the past 5 years. The vaccine record is attached.

[Note: The Advisory Committee on Immunization Practices recommends that all first-year college students up to age 21 Years should have at least 1 dose of Meningococcal ACWY vaccine not more than 5 years before enrollment, preferably on or after their 16th birthday, and that young adults aged 16 through 23 years may choose to receive the Meningococcal B vaccine series. College and university students should discuss the Meningococcal B vaccine with a healthcare provider.]

☐ read, or have had explained to me, the information regarding meningococcal disease. I (my child) will obtain immunization against meningococcal disease within 30 days from my private health care provider or Hobart and William Smith Colleges, Hubbs Health Center.

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

Student Signature: _____ Date _____
(Parent / Guardian if student is a minor)

Print Student's name _____ Student _____/_____/_____
Date of Birth

Student
E-mail Address _____

Student
Mailing Address _____

_____

Student
Phone number (____)_____

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HOBART AND WILLIAM SMITH COLLEGES

COVID-19 VACCINATION RESPONSE FORM

Hobart and William Smith Colleges require all HWS community members to be fully vaccinated for COVID-19 (per CDC, a person is fully vaccinated two weeks after receiving all doses of the primary series of COVID-19 vaccination) or submit a waiver request below.

Check ONE box and sign below:

I have (for students under the age of 18: My child has):

☐ had the COVID-19 primary vaccination. The vaccine record is attached.

☐ read, or have had explained to me, the information regarding COVID-19. I (my child) will obtain a COVID-19 vaccination within 30 days from my private health care provider or from locally available vaccination options.

☐ read, or have had explained to me, the information regarding COVID-19. I understand the risks of not receiving the vaccine. I have decided that I (my child) will **not** obtain vaccination at this time.

Student Signature: _____ Date _____
(Parent / Guardian if student is a minor)

Print Student's name _____ Student _____/_____/_____
Date of Birth

Student
E-mail Address _____

Student
Mailing Address _____

_____

Student
Phone number (____)_____

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