

Report of Medical History

Family Name (Print)	First Name	Middle	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth
Home Address (Number & Street)	City or Town	State	Zip Code	
E-mail Address	Social Security #		RIN (Rensselaer ID Number)	
Parent/Guardian/ Emergency Contact	Business Telephone		Home Telephone Number	
Semester you will begin at Rensselaer: <input type="checkbox"/> Fall <input type="checkbox"/> Spring <input type="checkbox"/> Summer Year _____ <input type="checkbox"/> Freshman <input type="checkbox"/> Transfer <input type="checkbox"/> Graduate				
Were you previously a student at Rensselaer? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what year? _____				
Do you plan on participating in intercollegiate sports? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, sport(s) _____				

HEALTH INSURANCE COVERAGE

RPI mandates all students to have health insurance coverage. Students are charged the health insurance premium automatically. This fee may only be waived if:

1. The student has comparable health insurance coverage (routine and emergency care are required in Troy, NY area).
2. The student meets the waiver deadline.

Before you waive/enroll:

- Review the RPI health insurance coverage information on www.chickering.com
- Please check with your insurance company to make sure they provide comparable coverage in the Troy, NY area (routine and emergency care are required).

To waive:

- Complete online waiver procedure through chickering website by September 15th for the fall and February 15th for the spring.
- This process will need to be done yearly.

To enroll:

- Complete the online enrollment procedure through chickering website by the above deadlines.
- After enrolling, you will receive your insurance card in the mail to your designated address.

* If covered by another insurance, please attach a copy of both sides of your insurance card* (this doesn't constitute a waiver)

DUE DATE FOR THIS FORM:

June 15 for students enrolling for the Fall Semester • December 15 for student enrolling for the Spring Semester

Please Make Sure To Complete These Steps Before Sending This Form In:

- Check to make sure that this form is filled out completely. Pages 1 and 2 will be filled out by the student/parent. Please make sure that the bottom of page 2 has been signed by the student if over 18 or the parent/guardian if student is under 18. Pages 3 and 4 are to be filled out completely by your medical provider.
- Make sure your physical is within the last 12 months and the form is complete and signed by your medical provider.
- All of your immunizations are complete and properly filled out including exact dates, copies of lab reports for any titers or chest x-rays performed and that all medical provider information is filled out.
- Review Health Insurance Information at www.chickering.com. Remember the online procedure needs to be completed whether you are waiving or enrolling in the insurance by the deadline listed above.
- IF COVERED BY ANOTHER INSURANCE, PLEASE ATTACH A COPY OF BOTH SIDES OF YOUR INSURANCE CARD

IF THERE IS ANYTHING MISSING FROM YOUR FORM, IT WILL BE RETURNED VIA EMAIL. Please provide the best email address to contact you about missing information: _____

If you would rather receive notification through mail, please check here

Medical History

Name _____

Are you currently taking any medications, including inhalers? Yes No Please list: _____

Are you taking any vitamin or herbal supplements? Yes No Please list: _____

Do you have any allergies to medications or environmental agents? Yes No Please list: _____

PERSONAL HISTORY

Have you had?	Yes	No		Yes	No		Yes	No		Yes	No			
Anemia			Lyme Disease			Eye, Ear, Nose or Throat Trouble			Stomach, Intestinal, Gallbladder Trouble or Stones			Depression		
Asthma			Malaria			Frequent Urination			Weakness, or Paralysis			Eating disorder		
Bone or Joint Disease/Injury			Mononucleosis/ Epstein Bar Virus			Gum or Tooth Trouble				Wheezing			Insomnia	
Chicken Pox			Scarlet Fever			Heat Cramps			Surgery				Substance Abuse/ Dependency	
Cancer			Seizures			Heart Murmur			Appendectomy			FEMALES ONLY		
Concussion/Head Injury			Sickle Cell Disease			High or Low Blood Pressure				Bone or joint surgery				Abnormal PAP Smear
Diabetes			Tuberculosis/Tumor			Pain/Pressure in Chest			Hernia Repair				Endometriosis	
Heart Disease			Thyroid Problem			Palpitations (heart)			Tonsillectomy			Excessive Flow		
Hernia/ Rupture			Venereal Disease			Recent Weight loss or gain			Other			Irregular Periods, Lack of Period		
Jaundice			Back Problems			Recurrent Headaches			ADD/ADHD			Polycystic Ovarian Syndrome		
Kidney Disease			Chronic Cough			Shortness of Breath			Anxiety			Severe Cramps		
Liver Disease/ Hepatitis			Dizziness or Fainting						Bipolar Disorder					

Alcohol Use Yes No Amount per week _____ Tobacco Use Yes No Amount per week _____

1. Have you consulted or been treated by clinics, physicians, healers or other practitioners within the past five years? Yes No
2. Have you had any illness or injury or been hospitalized other than already noted? Yes No
3. Are you missing any paired organ (i.e. kidney, testicles)? Yes No
4. Has your physical activity been restricted during the past five years? Yes No
5. Have you had back problems severe enough to cause you to stop regular activities for more than a day? Yes No
6. Have you been rejected/ discharged from military service because of physical, emotional, or other reason? Yes No
7. Have you ever been cared for by a mental health clinician? Yes No
8. Have you ever been hospitalized for a mental health problem? Yes No
9. Would you like a referral to a psychiatrist and/or mental health clinician at RPI? Yes No

Please answer all questions above. Comment on all positive answers, including dates, reasons and duration. Additional paper may be used.

FAMILY HISTORY

	Age	State of Health	Occupation	Age at Death	Cause of Death
Father					
Mother					
Brothers					
Sisters					

Have any of your relatives ever had the following?

	Yes	No	Relationship		Yes	No	Relationship
Arthritis				High Cholesterol			
Cancer				Kidney Disease			
Diabetes				Mental Illness			
Heart Disease/ Sudden death before age 55				Stomach or Intestinal Disease			
High Blood Pressure				Tuberculosis			

Your medical information is confidential and will not be released without your written consent. If you are under 18 years of age, your parents may have access to some of the data in your medical and counseling records. They will be notified if you are hospitalized. If you are over 18, it is your responsibility to inform your parents regarding your medical information.

- If you are under 18 years of age, the following needs to be signed by your parent/ guardian.

I give permission for my son/daughter to be treated by the Student Health Center including health and counseling services. I also authorize urgent or emergency treatment at Samaritan Hospital in Troy, NY. Financial coverage for medical care is subject to your insurance plan limitations.

Parent's/Guardian's Signature _____ Date _____

- If you are over 18 years of age, please read and sign the following release.

In the event of serious physical or mental illness, I hereby consent to the notification of the person listed here on the emergency contact.

Student's Signature _____ Date _____

Physical Examination

MUST BE WITHIN LAST 12 MONTHS. ALL INFORMATION IS REQUIRED AND MUST BE FILLED OUT BY A HEALTH CARE PROVIDER

Name: _____

Height _____ Weight _____ BMI _____ BP _____ Pulse _____

Skin: _____

Head: _____

Eyes: _____ Snellen R/20 _____ L/20 _____
Corrected R/20 _____ L/20 _____
Contact lens/glasses: _____

Ears: _____

Nose: _____

Mouth and Throat: _____

Neck: _____

Thorax: _____ Lungs: _____

Breast: _____

Spine/Back: _____

Heart: _____

Abdomen: _____

Genito-urinary (testicles): _____

Extremities: _____

Lymph Nodes: _____

Reflexes: _____

Laboratory exam: HgB / Hematocrit _____ Urine Sugar _____ Urine Protein _____

Please answer all following questions:

- Does this student have a medical condition for which ongoing health care is required? Yes No
Please describe, if yes. _____
- Does this patient use an inhaler prior to exercise? Yes No
- Is there any evidence of a heart murmur? ?Yes ?No If yes, has the murmur been evaluated by Echo? Yes No
- Has the murmur been determined by workup to be benign and not interfere with activity? Yes No
- Has this patient had a history of serious head injury/concussion? Yes No
Please describe, if yes. _____
- May this student participate in athletic activities? Are there any restrictions or contraindications? Yes No
Please describe, if yes. _____
- Are there any special braces or pads to be worn for sports? Yes No
Please describe, if yes. _____
- This patient is in good physical condition and may participate in unlimited physical activity including contact varsity level sports, non-contact varsity level sports, intramurals and ROTC. If no, please describe Yes No

Recommendations for the physical and mental health care at RPI? _____

Signature of the Health Care Provider _____ Date of Exam _____

Health Care Provider's Name: _____

Address: _____

Telephone Number: (_____) _____ - _____ Fax Number: (_____) _____ - _____

Immunization Verification

MUST BE COMPLETED BY A HEALTHCARE PROFESSIONAL IN ENGLISH AND ITS ENTIRETY. THIS IS REQUIRED PRIOR TO REGISTRATION.

Please submit dates in MM/DD/YYYY Format

Required Immunizations:

MMR (combined measles, mumps, rubella) – Requirements for vaccine: <ul style="list-style-type: none"> TWO doses required after 1st birthday and at least 28 days apart and after 01/01/1968 NYS Health Department Law 	Dose #1: ____/____/____ Dose #2: ____/____/____
MEASLES (if MMR not given) : ONE of the following is required — NYS Health Department Law <ul style="list-style-type: none"> TWO doses required after 1st birthday and at least 28 days apart and after 01/01/1968 OR Titer (blood test, serology) confirming immunity — MUST ATTACH LAB REPORT 	Dose #1: ____/____/____ Dose #2: ____/____/____ Titer: ____/____/____ Result: _____
MUMPS (if MMR not given) : ONE of the following is required — Rensselaer Requirement <ul style="list-style-type: none"> TWO doses required after 1st birthday and after 01/01/1968 OR Titer (blood test, serology) confirming immunity- MUST ATTACH LAB REPORT 	Dose #1: ____/____/____ Dose #2: ____/____/____ Titer: ____/____/____ Result: _____
RUBELLA (if MMR not given) : ONE of the following is required — NYS Health Department Law <ul style="list-style-type: none"> ONE dose required after 1st birthday and after 01/01/1968 OR Titer (blood test, serology) confirming immunity — MUST ATTACH LAB REPORT 	Dose #1: ____/____/____ Titer: ____/____/____ Result: _____
MENINGITIS — Rensselaer Requirement <ul style="list-style-type: none"> Required within the past 3-5 years 	Type _____ Date ____/____/____
TETANUS/DIPHTHERIA (DTP, Td, DT, TDaP) — Rensselaer Requirement <ul style="list-style-type: none"> Required booster within last 10 years 	Type _____ Date ____/____/____
TUBERCULOSIS TESTING (PPD) — Rensselaer Requirement <ul style="list-style-type: none"> A PPD skin test or a QuantiFERON®? TB Gold blood test. You must submit either the PPD (including date placed, date read, results in mm induration, with a signature from a healthcare professional), or a copy of QuantiFERON®? TB Gold blood test report. Test must be performed in the US and within the last 12 months 	Date PPD Placed _____ Date PPD Read _____ PPD Result _____ mm ____
If the result of the PPD or the QuantiFERON® TB Gold blood test is positive (a positive PPD is a result ≥ 10 mm induration) the student is required to : <ol style="list-style-type: none"> Attach a copy of a chest x-ray report done in the USA taken within the last 12 months Treatment received (i.e. INH), including medications and dates of treatment <input type="checkbox"/> Yes <input type="checkbox"/> No Treatment options were discussed and treatment was denied <input type="checkbox"/> Yes <input type="checkbox"/> No 	CXR Result: ____ Date ____/____/____ Medications Received: _____ Duration/ Dates of Treatment: Date ____/____/____ to ____/____/____

Strongly Recommended Immunizations: (All Immunizations are available at the Student Health Center, excluding Varicella)

GARDISIL <ul style="list-style-type: none"> There are THREE doses for this vaccine 2nd dose 2 months from initial dose, 3rd dose 6 months from initial dose 	Dose #1: ____/____/____ Dose #2: ____/____/____ Dose #3: ____/____/____
HEPATITIS A <ul style="list-style-type: none"> There are TWO doses for this vaccine 2nd dose 6-12 months after initial dose 	Dose #1: ____/____/____ Dose #2: ____/____/____
HEPATITIS B <ul style="list-style-type: none"> There are THREE doses for this vaccine 2nd dose 1 month from initial dose, 3rd dose 6 months from initial dose 	Dose #1: ____/____/____ Dose #2: ____/____/____
VARICELLA (Chicken Pox) Vaccination/ Disease <ul style="list-style-type: none"> There are TWO doses for this vaccine Need to be given at least 28 days apart 	Dose #1: ____/____/____ OR Date of Disease ____/____/____ Dose #2: ____/____/____ Titer: ____/____/____ Result: _____

Healthcare Professional: By signing below, you attest that all information supplied in this section is true and correct to the best of your knowledge.

Signature of the Health Care Provider _____

Date _____

Health Care Provider's Name: _____

Address: _____

Telephone Number: (____) ____ - ____ Fax Number: (____) ____ - ____

*Stamp may be used, but must be accompanied by signature and date



Rensselaer

Return all information to:
Student Health Center — RPI
110 8th Street — 3200 Academy Hall
Rensselaer Polytechnic Institute, Troy, NY 12180
(518) 276-6287 Fax (518) 276-8573