Dear Student:

Congratulations and welcome to Nyack College!

The Office of Student Health Services is committed to providing you with quality health care. Our mission is to provide basic medical care and health education in a safe setting of physical, emotional and spiritual comfort. We are also a source of referrals to other health care providers and facilities as needed. Through the health assessment process, we will select the appropriate first level care and provide basic first aid follow-up.

The State of New York requires that all students document their MMR (Measles, Mumps, and Rubella) immunizations and respond to the meningitis immunization choice prior to being enrolled at a college or university. A link to the New York State Immunization Requirements form has already been sent to you by Nyack's Admissions Office. The completed and signed form must be returned to the Admissions Office in order for you to be officially enrolled at Nyack College.

When you are an enrolled student, the Office of Student Health Services requires each new incoming student to submit additional health information so that you can be served most effectively. The following completed documents must be provided directly to the Office of Student Health Services.

- **Personal Health Report Form**
- **Physical Examination Form**
- **Student Health Services Authorization Form**

Please have your physician complete the forms to ensure that our office has the most accurate information regarding your current health status on file. At your earliest convenience, please return all ***completed*** forms to: Nyack College, Office of Student Health Services, 1 South Blvd, Nyack, NY 10960.
(Please DO NOT send Forms to Admissions, or Athletics or any other department.)

We encourage all students to maintain adequate health insurance.
If you do not have health insurance, please consider the insurance options available at
www.healthcare.gov or www.ehealthinsurance.com.

We look forward to meeting your basic health care needs during your time at Nyack. The Office of Student Health Services is not staffed during the summer. Please direct any questions to the Student Development Office by calling 845-675-4790 or by emailing healthservices@nyack.edu.

Thank you,

The Office of Student Health Services Department

STUDENT HEALTH SERVICES AUTHORIZATION FORM

I, _____, give my consent to receive health services at Nyack College
(Print full name)
in the event of an emergency which may require that I must be seen or assessed by the Office of Student Health Services.

In the case of an emergency or accident that requires that I _____
(print full name)
should require transportation to the hospital for further evaluation or treatment; the Office of Student Health Services has my consent to receive updated information on my medical status.

Because many doctors and hospitals will not treat without appropriate authorization or until the parent/ guardian is located, this authorization is effective in the event of an emergency and/or when the consent and approval of the undersigned cannot be quickly obtained.

It is further understood that Nyack College and/or its representatives shall not be liable in any way as a result of exercising the authority herein conferred.

_____

Adult Student (Age 18 & older) Signature Date

_____

Legal Guardian or Parent's Signature of minor Date

_____

Minor Student's Signature Date

NYACK COLLEGE OFFICE OF STUDENT HEALTH SERVICES
PERSONAL HEALTH REPORT FORM

This information is strictly CONFIDENTIAL and will be used as an aid to provide necessary health care while you are a Nyack College student. Information supplied will become a part of your health record, will not influence your standing at the College and will not be released to anyone except by your written authorization.

RETURN COMPLETED FORM TO: OFFICE OF STUDENT HEALTH SERVICES
NYACK COLLEGE, 1 SOUTH BLVD., NYACK, NY 10960-3698
DO NOT SEND FORM TO ADMISSIONS, ATHLETICS DEPARTMENT OR SCHOOL OF NURSING.

NAME: Last:	First:	Middle:	Maiden:……
DATE OF BIRTH:	Social Security Number:		AGE:
HOME ADDRESS:			

PARENT/LEGAL GUARDIAN_____ PARENT/GUARDIAN # (Work)_____ (Cell) _____
STUDENT PHONE # (Cell) _____ (Home)_____
LOCAL ADDRESS _____

NOTIFY IN CASE OF EMERGENCY: _____ RELATIONSHIP_____
EMERGENCY CONTACT (Home): _____ (Cell): _____
ADDRESS: _____

U.S. CITIZEN: Yes or No (circle one)

CLASS: Freshman/Sophomore/Junior/Senior **SEX:** ____M ____F **MARITAL STATUS**: _____

INSURANCE INFORMATION: **(Please staple copy of both sides of insurance card to this form)**
NAME OF INSURANCE:_____INS. PHONE #:_____
SUBSCRIBER'S NAME:_____POLICY NO:_____GROUP NO:_____
PRIMARY PHYSICIAN:_____OFC. PHONE #:_____FAX #:_____
ADDRESS:_____

PERSONAL HISTORY: Please attach a separate sheet explaining all "yes" answers to the conditions listed below.

HAVE YOU HAD?	YES	NO	HAVE YOU HAD?	YES	NO	HAVE YOU HAD?	YES	NO
ALLERGIES, SEASONAL			HIGH BLOOD PRESSURE			SCARLET FEVER		
ARTHRITIS			JAUNDICE			SEIZURE DISORDERS		
ANOREXIA/BULIMIA			MALARIA			SMALL POX		
ASTHMA			MENTAL ILLNESS			STOMACH ULCERS		
CANCER			MIGRAINE HEADACHES			"STREP" THROAT		
CHICKEN POX			MONONUCLEOSIS			TONSILLITIS		
DIABETES			MUMPS			SUICIDAL TENDENCIES		
DIPHTHERIA			NERVOUS BREAKDOWN			THYROID FEVER		
DYSMENORRHEA			PNEUMONIA			THYROID DISORDER		
EMOTIONAL ILLNESS			POLIOMYELITIS			WEIGHT GAIN/LOST		
FREQUENT COLDS			RHEMATIC FEVER			SURGERY		
HEART DISEASE			RUBELLA/GER MEASLES			TUBERCULOSIS		
HEPATITIS			RUBELLA/REG MEASLES			WHOOPING COUGH		

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HOPITALIZATIONS:

Reasons: DATE

1. _____ _____
2. _____ _____
3. _____ _____

LIST ALLERGIES TO DRUGS, FOODS, POLLEN, MOLD, OTHER: COMMENTS:

_____ _____
_____ _____
_____ _____
_____ _____

LIST MEDICATION TAKEN REGULARLY: COMMENTS:

_____ _____
_____ _____
_____ _____
_____ _____

LIST ANY ILLNESS OR INJURY OTHER THAN ALREADY NOTED:

_____
_____
_____
_____
_____

FAMILY HISTORY

DISEASE	YES	NO	RELATIONSHIP	DISEASE	YES	NO	RELATIONSHIP
ALLERGY				HEART DISEASE			
CANCER				KIDNEY DISEASE			
DIABETES				NERVOUS DISORDERS			
EPILEPSY				TUBERCULOSIS			

By signing this, I affirm that all information in this document is correct and complete. I also agree to inform the Office of Student Health Services of any changes in my health or in the information on this form. I hereby authorize the release of my medical records (health history, physical exam, immunizations, etc) to the Athletics staff, Alliance Theological Seminary or any Nyack College campus, if needed. All records/medical information will be kept confidential.

_____ _____ _____
Student's Signature Date Parent's Signature (in addition to student's, if student is minor)

PLEASE LIST DRUG ALLERGIES

HEALTH SERVICES PHYSICAL EXAMINATION FORM
(TO BE COMPLETED BY MEDICAL DOCTOR OR NURSE PRACTITIONER)

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Name (Last, First, MI): _____ Date of examination:_____ Sex: _____
Age: _____Date of Birth: _____Blood Pressure: _____Pulse Rate: _____
Height: _____ Weight: _____

Contact Lenses: yes_____ No_____ Vision: Corrected_____ R 20/_____
Glasses: yes_____ No_____ Uncorrected_____ L20/_____

REVIEW OF SYSTEMS: Please note any abnormalities or history of past medical illness or chronic disease, along with current status.

CLINICAL EALUATION: check each item in proper column. Enter NE if not evaluated.	NORMAL	ABNORMAL	**NOTE:** Give details for each abnormality with corresponding item number.
1. Head, Neck, Face and Scalp			
2. Nose and Sinuses			
3. Mouth and Throat			
4. Teeth and Gingiva			
5. Ears			
6. Eyes			
7. Lungs, Chest and Breasts			
8. Heart			
9. Vascular System			
10. Abdomen and Viscera			
11. Ano-rectal			
12. Endocrine System			
13. G-U System			
14. Upper Extremities			
15. Feet			
16. Lower Extremities			
17. Spine, other Muscular-Skeletal			
18. Skin and Lymphatic			
19. Neurologic			
20. Psychiatric			
21. Is there loss or seriously impaired function of any paired organ? Yes No			
Do you have any general comments: _____ _____ _____			

NAME OF PHYSICIAN: _____ SIGNATURE: _____
DATE OF EXAMINATION: _____ PHYSICIAN TELEPHONE: _____
ADDRESS: _____ FAX #: _____
_____