Health and Physical Examinations

The State University of New York requires a Health Report and Physician’s Certificate to be maintained for every student in the system.

Accepted students must submit a completed Health and Physical Examination form prior to the start of the Indoctrination or Orientation period. Students may have this physical examination completed by a physician of their choice. Upon completion of the entire physical examination, the original forms can be brought with you to campus on your placement testing date. For those taking placement tests off campus, and others, your form may be mailed to the Health Services as soon as possible. Please make copies of all completed and signed forms for your records. Your enrollment at Maritime is contingent on the completion of all health forms.

Applicants who have applied for an ROTC scholarship or admission to a service academy may request a copy of his/her physical examination report from the Department of Defense Medical Review Board. Please note that certain required items are not found on the DODMER, and we therefore require that you use the form provided. It is critical that a current immunization record is included and that the form is complete.

In no case will a student be allowed to participate in the Indoctrination Program or start fall classes without a physical examination report on file at the college. Failure to complete the Indoctrination Program will prevent a student from enrolling at the college in any Regimental Program.

The general physical requirements for a Coast Guard Merchant Mariner Credential (MMC) are found in the College catalog and on the U.S. Coast Guard National Maritime Center’s (NMC’s) website. Questions regarding these requirements may be directed to the Health Services. Applicants who do not meet the physical requirements for licensure as an officer in the Merchant Marine, but who are otherwise fully capable of participating in all facets of the program without endangering themselves or others, may attend Maritime College.

It is recommended that accepted students who require the use of prosthetics have the necessary prosthetic available due to the physical demands of the Indoctrination program.

New York State law requires college students to be immunized against measles, mumps and rubella. The law applies to all students born on or after January 1, 1957. Persons born prior to January 1, 1957 must provide proof of age. All undergraduate and graduate students born on or after this date must show proof of immunity. MMR requires two doses of vaccine. A tuberculin skin test must be administered within six months of entry date. A tetanus inoculation must be administered within the last five years. Exemption from these requirements is possible for those documenting valid religious or medical reasons.

On July 22, 2003 NYS Public Health Law 2167 requiring colleges and universities to distribute information about meningococcal disease and vaccination to all students meeting enrollment criteria was signed by the Governor. Meningococcal disease is a bacterial infection commonly referred to as meningitis. Colleges in New York State are required to maintain a record of student response. Please refer to www.health.ny.gov/diseases/communicable/ meningococcal/factsheet.mtm for information about meningitis.
Health Report Checklist

Please have your physician complete and sign the following medical form. Completed forms should be mailed to the address indicated below. This form should be on file before a student’s registration can be considered final. Registration procedures may be delayed if the form has not been received.

The information contained in this form is accessible only to the professional staff of Health Services and will not be released without the written authorization of the student or pursuant to a lawfully issued subpoena. The authority to request this information is found in section 355 of the Education Law.

Medical forms can be submitted on your placement testing date. For those taking placement tests off campus, and others, your form may be mailed to:

**Health Services**
SUNY Maritime College
6 Pennyfield Avenue
Throggs Neck, NY 10465

**DUE DATE:**
July 15, 2014

In order to expedite successful processing of your Health Report, please place a check mark in the box to indicate the following are complete, Please note that pkgs must be submitted in its entirely. **No forms will be accepted separately. INCOMPLETE PKGS WILL NOT BE ACCEPTED.**

**ALL STUDENTS:**
___Student Information
___Emergency Contact Information
___Under 18 Notarization
___Medical History
___Vaccination Records
   - MMR (2 doses required or titer)
   - Polio Vaccinations (minimum of 3 doses)
   - Tetanus (within the last 5 years)
___T/B (test within 6 months of entry to school)
___Meningitis Information Response Form
___Sickle Cell Trait Status Form (Must accompany the physical pkg. This is not optional. It is a mandated regulation by the state)
___Clinical Evaluation

**REGIMENTAL STUDENTS ONLY:** If you are considering regiment at a later time please have the forms filled out now to avoid any delays
___Color Vision/Ishihara 14-Plate Test (contact Health Services for other acceptable tests)
___Vision Test (corrected/uncorrected) ___Hearing Test ___List of conditions
ALL STUDENTS MUST COMPLETE THE FOLLOWING:

STUDENT INFORMATION

Name _______________________________________________________________________________

Last                   First                   Middle

Address___________________________

STREET                  CITY              STATE              ZIP

Birth date: ___ ___/___ ___/___ ___ ___ ___ Age: ____________ Female ___ Male___

E-mail ________________________________________ Phone number (_____) __________________

Entering Year:        FALL 20___ ___        SPRING 20___ ___        SUMMER 20___ ___

EMERGENCY CONTACT INFORMATION

Name _______________________________________________________________________________

Last                   First                   Middle

Relationship ____________________________

Work (____) ____________________________ Home (____) __________________________

E-mail ________________________________________ Cell (____) __________________

Address: __________________

STREET                  CITY              STATE              ZIP

UNDER 18 NOTARIZATION

To Parents and Guardians of Applicants under Eighteen:

To procure care that may be necessary for our students and to protect the physician and institutions involved, it is necessary that you sign the consent for treatment statement. While every reasonable effort is made to contact families in the event of serious illness or injury, this is not always possible within a short period of time; therefore, the consent form is necessary to provide appropriate care.

I ____________________________________________ (Print Full Name of Parent/Guardian) pursuant to the authority vested in me as Parent/Guardian of

______________________________________________ (Print Full Name of Student), do authorize the Medical Staff at SUNY Maritime College, upon consultation with a practicing physician or surgeon to exercise for me and on my behalf, all rights and duties with reference to consenting to appropriate medical, psychiatric, and surgical treatment, anesthetics, medicines and hospitalization, including care and treatment, by any hospital, staff surgeon, physician or radiologist which they may deem necessary for the emergency care of my son/daughter (circle one).

Signed ________________________________________________________    Date_______/_______/_______

Subscribed before me this ____________ day of ______________________20_______    Notary Public (with Seal)
Student Name (Print):______________________________________

Please check: ____Civilian ____Regiment ____NROTC ____STA-21 ____Active Duty

MEDICAL HISTORY  ALL STUDENTS MUST COMPLETE THE FOLLOWING:

Check those of the following diseases or conditions the student has or had:

__Chicken Pox  __Epilepsy/seizures
__Measles  __Depression
__English or Red  __Anxiety
__Rubella (German)  __ADD/ADHD
__Mumps  __Speech impairment
__Scarlet Fever  __Tuberculosis or TB Contact
__Whooping Cough  __Diabetes
__Diphtheria  __Anemia
__Frequent Colds  __Malaria
__Frequent Sore Throats  __Mononucleosis
__Hearing loss/hearing aid  __Infectious Jaundice or Hepatitis

Injuries (severe): ____________________________________________________________

Drug or food allergies: _______________________________________________________

If you now receive allergy injections and plan to continue while in school, please indicate YES___ NO__

Medical problems other than those listed above: __________________________________

Current short-term medications: ________________________________________________

Past or present long-term medications: __________________________________________

Past or present counseling for nervous or emotional conditions: _______________________

If so, please list diagnosis: ____________________________________________________

FAMILY HISTORY: (List all familial diseases: Diabetes, Tuberculosis, Mental Illness, Other): ________
Student Name (Print): ________________________________

Please check: ___Civilian ___Regiment ___NROTC ___STA-21 ___Active Duty

VACCINATION RECORDS [ALL STUDENTS MUST COMPLETE THE FOLLOWING:]

To be completed by a Health Care Provider. Or, attach a copy of your official high school, previous college or health care provider immunization record. Check appropriate line. Persons born prior to January 1, 1957 must provide proof of age.

M.M.R. (Measles, Mumps, Rubella) if given instead of individual immunizations:

1. ___ Dose 1- Immunized no more than 4 days prior to first birthday……………..Date:____/____/____
2. ___ Dose 2-Immunized at least 30 days after first dose………………………….Date:____/____/____
3. ___ Positive titer…………………………………………………………………. (Attach lab report)
4. ___ Physician documentation of having the disease……………………………. (Attach documentation)
5. ___ Born before January 1, 1957 and therefore considered immune

Measles (Rubeola):

1. ___ Dose 1- Immunized no more than 4 days prior to first birthday……………..Date:____/____/____
2. ___ Dose 2-Immunized at least 30 days after first dose………………………….Date:____/____/____
3. ___ Positive titer…………………………………………………………………. (Attach lab report)

Mumps:

1. ___ Immunized with vaccine at 12 months or later……………………………Date:____/____/____
2. ___ Positive titer…………………………………………………………………. (Attach lab report)

Rubella:

1. ___ Immunized with vaccine at 12 months or later……………………………Date:____/____/____
2. ___ Positive titer…………………………………………………………………. (Attach lab report)

Polio: (Minimum 3 doses for all students 18 and under. For those 19 and over record previous doses):

1. ___ Dose 1………………………………………………………………Date:____/____/____
2. ___ Dose 2………………………………………………………………Date:____/____/____
3. ___ Dose 3………………………………………………………………Date:____/____/____

Tetanus-Diphtheria (Minimum 3 doses required for all students):

1. ___ Dose 1………………………………………………………………Date:____/____/____
2. ___ Dose 2………………………………………………………………Date:____/____/____
3. ___ Dose 3………………………………………………………………Date:____/____/____

Tuberculosis: (within 6 months of entry)

1. ___ PPD (Mantoux)…………………………………………Date Administered:____/____/____

Date Interpreted: ____/____/____ Results: ________________________________

Physician’s Signature/stamp: ______________________________ Date:____________________

Return This Packet to Health Services by July 15, 2014
MENINGITIS INFORMATION RESPONSE /

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 complete this section. No institution shall permit any student to attend the institution in excess of 30 days without complying with this law. The 30 day period may be extended to 60 days if a student can show a good faith effort to comply.

Check one box and sign below:

_____ I have received the meningococcal meningitis immunization within the past 10 years.

Date Received: ____________

_____ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risk of not receiving the vaccine and I have decided that I (my child) will not obtain immunization.

_____ I will have my family physician provide the vaccine.

____________________________________  ______________________________________
Student’s Signature                  Parent/Guardian Signature (if under 18 years)

__________________________
Date
Student Name (Print): __________________________________

Please check: ___Civilian ___Regiment ___NROTC ___STA-21 ___Active Duty

About Sickle Cell Trait: [ALL STUDENTS MUST COMPLETE THE FOLLOWING:]

- Sickle cell trait is an inherited condition of the oxygen-carrying protein, hemoglobin, in red blood cells.
- Although sickle cell trait is most predominant in African-Americans and those of Mediterranean, Middle Eastern, Indian, Caribbean, and South and Central American ancestry, persons of all races and ancestry may test positive for sickle cell trait.
- Sickle cell trait is usually benign, but during intense, sustained exercise, hypoxia (lack of oxygen in the tissue) may cause red blood cells to change shape from a normal disc shape to a crescent or “sickle” shape. Such cells can accumulate in the bloodstream and “logjam” blood vessels, blocking circulation to muscles, as well as the heart, leading to a collapse from the decreased circulation of blood.

SUNY Maritime College requires that all students be tested for sickle cell trait status, regardless of race, and show proof of a prior test and provide documented results of that test to the institution

Proof of a prior test must be supplied in the form of:

1. A lab report with the results of a Hemoglobin solubility test or Hemoglobin electrophoresis test (a total Hemoglobin count will not be accepted)

2. A physician’s letter stating the date of the test and the results. Letter must be on physician’s letterhead with a valid signature, NOT a stamp. Notes on physician’s prescription pads WILL NOT be accepted.

NOTE: Most individuals are tested for the Sickle Cell Trait as a newborn. The student may contact their pediatrician for more details. The student may also find information at their state’s Board of Health or find their state’s Newborn Screening Center [http://genes-r-us.uthscsa.edu/resources/consumer/statemap.htm]

______________________________  __________________________________
Student’s Signature                    Parent/Guardian Signature (if under 18 years)

_________________________
Return This Packet to Health Services by July 15, 2014
Date

**ALL STUDENTS MUST COMPLETE THE FOLLOWING:**

Student Name (Print): __________________________________________

Check all that apply: ____Civilian____Regiment ___NROTC ___STA-21 ___Active Duty

**CLINICAL EVALUATION:**

Height_________ Weight___________

Pulse___________ Rhythm: ( ) Regular  ( ) Irregular

Respirations___________ Blood Pressure_____________

Vision: R 20/____ L 20/_____  Corrected: R 20/____ L 20/_____  

Glasses ___Y ___N  Contacts ___Y ___N  Hearing Aid ___Y ___N

Check each item in proper column. Enter N.E. if not evaluated.

<table>
<thead>
<tr>
<th>Item</th>
<th>NORMAL</th>
<th>ABNORMAL</th>
<th>Give details/history of each abnormality</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. General Appearance</td>
<td></td>
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<tr>
<td>2. Head, Neck</td>
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<tr>
<td>3. Ears, Nose and Mouth/Throat</td>
<td></td>
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<tr>
<td>4. Eyes (disease/injury/surgery)</td>
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<tr>
<td>5. Neck, Thyroid, Lymph Nodes</td>
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<tr>
<td>6. Lungs, Chest</td>
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<tr>
<td>7. Heart (attack/surgery/pacemaker)</td>
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<tr>
<td>8. Abdomen</td>
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<tr>
<td>9. G-U System/hernia</td>
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<tr>
<td>10. Neurologic</td>
<td></td>
<td></td>
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<tr>
<td>11. Psychiatric</td>
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<tr>
<td>12. Upper Extremities:</td>
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<td></td>
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<tr>
<td>Shoulders/ arm</td>
<td></td>
<td></td>
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<tr>
<td>Elbow/forearm</td>
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<tr>
<td>Hand/wrist</td>
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<td></td>
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<tr>
<td>Fingers</td>
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<tr>
<td>13. Lower Extremities:</td>
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<tr>
<td>Hip/thigh</td>
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<tr>
<td>Knee</td>
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<tr>
<td>Leg/ankle</td>
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<td></td>
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<tr>
<td>Foot</td>
<td></td>
<td></td>
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<tr>
<td>14. Spine</td>
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</tbody>
</table>
Physician’s Signature/stamp: __________________________________________
Student Name (Print): __________________________________________

Check all that apply: ___Civilian___ Regiment ___NROTC ___STA-21 ___Active Duty

CLINICAL EVALUATION CONT’D:

Cleared to participate in physical activity: Yes___ No___ If “No” what activities are to be eliminated:
_____________________________________________________________________________________

Evidence of anxiety or emotional instability: Yes___ No___ If Yes, please give specifics: __________
_____________________________________________________________________________________
_____________________________________________________________________________________

Professional opinion of this applicant’s ability to meet the physical and emotional demand of Maritime
College: _____________________________________________________________________________

Do you recommend any further investigation or treatment: _____________________________
_____________________________________________________________________________________

***************************************************************************************

Name of Examining Physician: (Please Print) __________________________________________

Physician’s Signature: __________________________ Date: __________________

Address: __________________________ Telephone: ________________
Street City/State Zip Code
ALL REGIMENTAL STUDENTS MUST COMPLETE THE FOLLOWING:
Civilian Students do NOT need to complete the following

Student Name (Print): ______________________________________

Please check: ____Civilian____ Regiment ____NROTC ____STA-21 ____Active Duty

COLOR VISION TEST

14 PLATE TEST REQUIRED: GO TO HEALTH SERVICES WEBSITE FOR ACCEPTABLE TESTS.

<table>
<thead>
<tr>
<th>TEST USED</th>
<th>NO. PLATES PASSED</th>
<th>NO. PLATES FAILED</th>
</tr>
</thead>
</table>

Name of Examining Physician: (Please Print) __________________________________________

Physician’s Signature: ___________________________ Date: __________________________

Address: ____________________________________________________________________ Telephone: ________________

Street City/State Zip Code

VISION TEST

<table>
<thead>
<tr>
<th>Right: 20/</th>
<th>Corrected: Right: 20/</th>
<th>Left: 20/</th>
</tr>
</thead>
</table>

Name of Examining Physician: (Please Print) __________________________________________

Physician’s Signature: ___________________________ Date: __________________________

Address: ____________________________________________________________________ Telephone: ________________

Street City/State Zip Code

HEARING TEST

<table>
<thead>
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<th>Left:</th>
</tr>
</thead>
</table>

Name of Examining Physician: (Please Print) __________________________________________

Physician’s Signature: ___________________________ Date: __________________________

Address: ____________________________________________________________________ Telephone: ________________

Street City/State Zip Code
ALL REGIMENTAL STUDENTS MUST COMPLETE THE FOLLOWING:
Civilian Students do NOT need to complete the following

Student Name (Print): ___________________________________________

Check all that apply: ____Civilian____ Regiment ___NROTC ___STA-21 ___Active Duty

LIST OF CONDITIONS: check all that apply

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ear surgery</td>
<td></td>
<td></td>
<td>Limitations of any major joint</td>
<td></td>
<td></td>
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<tr>
<td>Deformities of face</td>
<td></td>
<td></td>
<td>Bone or joint surgery</td>
<td></td>
<td></td>
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<tr>
<td>Open tracheostomy</td>
<td></td>
<td></td>
<td>Dislocated joint</td>
<td></td>
<td></td>
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<tr>
<td>Poor vision</td>
<td></td>
<td></td>
<td>Recurrent neck or back pain</td>
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<tr>
<td>Glaucoma</td>
<td></td>
<td></td>
<td>Swollen or painful joints</td>
<td></td>
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<tr>
<td>Emphysema/COPD</td>
<td></td>
<td></td>
<td>Arthritis or bursitis</td>
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<tr>
<td>Collapsed lung/pneumothorax</td>
<td></td>
<td></td>
<td>Trick or locked knee</td>
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<tr>
<td>Irregular heart beat</td>
<td></td>
<td></td>
<td>Amputation or prosthesis</td>
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<tr>
<td>Heart murmur or valve replacement</td>
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<td></td>
<td>Carpal tunnel</td>
<td></td>
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<tr>
<td>Chest pain or angina</td>
<td></td>
<td></td>
<td>Difficulty walking or climbing</td>
<td></td>
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<tr>
<td>Heart attack/myocardial infarction</td>
<td></td>
<td></td>
<td>Sciatica or nerve pain</td>
<td></td>
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<tr>
<td>Congestive heart failure</td>
<td></td>
<td></td>
<td>Other bone/joint disorder</td>
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<tr>
<td>High blood pressure/hypertension</td>
<td></td>
<td></td>
<td>Motion/ sea sickness</td>
<td></td>
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<tr>
<td>Aneurysm or blockages</td>
<td></td>
<td></td>
<td>Impaired balance, or balance disorder</td>
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<tr>
<td>Pulmonary embolus or blood clots</td>
<td></td>
<td></td>
<td>Vertigo or dizziness</td>
<td></td>
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<tr>
<td>Gastrointestinal bleeding or ulcers</td>
<td></td>
<td></td>
<td>Numbness or paralysis</td>
<td></td>
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<tr>
<td>Crohn’s disease or ulcerative colitis</td>
<td></td>
<td></td>
<td>Head injury or skull fracture</td>
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<tr>
<td>Hepatitis or jaundice</td>
<td></td>
<td></td>
<td>Recurrent headaches</td>
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<tr>
<td>Gallbladder problems or stones</td>
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<td></td>
<td>Narcolepsy</td>
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<tr>
<td>Intestinal surgery</td>
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<td>Sleep apnea</td>
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<td>Any form of cancer</td>
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<td>Restless leg</td>
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<td>Hemophilia or polycythemia</td>
<td></td>
<td></td>
<td>Fainting spells or loss of consciousness</td>
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<tr>
<td>Any other blood disorders</td>
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<td></td>
<td>Stroke or TIA</td>
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<tr>
<td>Thyroid disease</td>
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<td></td>
<td>Brain tumor</td>
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<tr>
<td>HIV or AIDS</td>
<td></td>
<td></td>
<td>Other brain or nerve disease</td>
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<tr>
<td>Lymphoma or leukemia</td>
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<td></td>
<td>History of suicide attempt</td>
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<tr>
<td>Neurofibromatosis</td>
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<td></td>
<td>Schizophrenia</td>
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<tr>
<td>Skin tumors or cancer</td>
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<td></td>
<td>Alcohol or substance abuse</td>
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<tr>
<td>Scleroderma</td>
<td></td>
<td></td>
<td>Loss of memory or amnesia</td>
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<tr>
<td>Lupus</td>
<td></td>
<td></td>
<td>Other psychiatric disease or counseling</td>
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<td>Kidney transplant or dialysis</td>
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<td></td>
<td>Sleepwalking</td>
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<tr>
<td>Kidney stones</td>
<td></td>
<td></td>
<td>Bedwetting since age 12</td>
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<td></td>
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<tr>
<td>Protein/sugar/blood in urine</td>
<td></td>
<td></td>
<td>Sex change</td>
<td></td>
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<tr>
<td>Back surgery or injury</td>
<td></td>
<td></td>
<td>Allergic reactions</td>
<td></td>
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<tr>
<td>Ruptured/herniated disc</td>
<td></td>
<td></td>
<td>Other disease/surgery/hospitalization</td>
<td></td>
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<tr>
<td>Fractures requiring surgery</td>
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</tbody>
</table>

Physician’s Signature/stamp: ____________________________ Date: ____________________________

Return This Packet to Health Services by July 15, 2014