MARITIME COLLEGE
STATE UNIVERSITY OF NEW YORK

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

Return This Packet to Health Services by July 15, 2014

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)

Return This Packet to Health Services by July 15, 2014

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

_____

Return This Packet to Health Services by July 15, 2014

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:_____

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Student Name (Print): _____

Please check: ____Civilian____Regiment ___NROTC ___STA-21 ___Active Duty

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

Return This Packet to Health Services by July 15, 2014

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)

_____

Date

Return This Packet to Health Services by July 15, 2014

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.

	NORMAL	ABNORMAL	Give details/history of each abnormality
1.General Appearance			
2. Head, Neck			
3. Ears, Nose and Mouth/Throat			
4. Eyes (disease/injury/surgery)			
5.Neck, Thyroid, Lymph Nodes			
6. Lungs, Chest			
7. Heart (attack/surgery/pacemaker)			
8. Abdomen			
9. G-U System/hernia			
10. Neurologic			
11.Psychiatric			
12. Upper Extremities:			
Shoulder/arm			
Elbow/forearm			
Hand/wrist			
Fingers			
13. Lower Extremities:			
Hip/thigh			
Knee			
Leg/ankle			
Foot			
14. Spine			

Return This Packet to Health Services by July 15, 2014

Physician's Signature/stamp:_____ D
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

Return This Packet to Health Services by July 15, 2014

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.

TEST USED:	NO. PLATES PASSED:	NO. PLATES FAILED:

Name of Examining Physician: (Please Print) _____

Physician's Signature: _____Date:_____

Address: _____ Telephone: _____
Street City/State Zip Code

VISION TEST

Right: 20/ **Left: 20/**	**Corrected:** **Right: 20/** **Left: 20/**

Name of Examining Physician: (Please Print) _____

Physician's Signature: _____Date:_____

Address: _____ Telephone: _____
Street City/State Zip Code

HEARING TEST

Right:	**Left:**

Name of Examining Physician: (Please Print) _____

Physician's Signature: _____Date:_____

Address: _____ Telephone: _____
Street City/State Zip Code

Return This Packet to Health Services by July 15, 2014

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

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

Physician's Signature/stamp:_____Date:_____