

# REPORT OF HEALTH EVALUATION

## TO BE COMPLETED ONLY BY PHYSICIAN, PA OR NP

**To the Examining Healthcare Provider:** Please review the student's history and complete the form below. Comment on all positive answers. The information supplied will not affect his/her status; it will be used only as a background for providing health care if necessary. This information is strictly for the use of the Student Health and Counseling Center and will not be released without student consent. Please be sure to sign form.

M  F

STUDENT'S LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MIDDLE \_\_\_\_\_ SEX \_\_\_\_\_

STUDENT'S ID / SS # \_\_\_\_\_  DORMITORY RESIDENT \_\_\_\_\_  COMMUTER \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

### MANDATED BY NEW YORK STATE LAW

New York State requires all students attending its colleges and universities who were born on or after **JANUARY 1, 1957**, to be immunized against **Measles, Mumps and Rubella**. **TWO** immunizations against **Measles** and **ONE** each against **Mumps and Rubella**. All immunizations must have been live vaccines.

**IMMUNIZATIONS - Please give complete dates (Month/Day/Year)**

	Date(s) of Immunization			Date of Disease	Titre*
MMR	1st	2nd			*MUST attach
MMR Vz	1st	2nd			a copy of
Varicella					actual laboratory
Rubeola					report for any
Mumps					titre result(s)
Rubella				NOT acceptable	
Menomune/Menactra					
Polio					
Tetanus					
HBV	1st	2nd	3rd		

**I HAVE EXAMINED THE FOLLOWING:**

	FINDINGS:
1. Head, Ears, Nose & Throat	
2. Respiratory	
3. Cardiovascular	
4. Gastrointestinal	
5. Hernia(s)	
6. Eyes	
7. Genitourinary	
8. Musculoskeletal	
9. Metabolic/Endocrine	
10. Neuropsychiatric	
11. Skin	

**TST I.D. (Mantoux) Mandatory**

Date administered: \_\_\_\_\_  
 Date read: \_\_\_\_\_ Results \_\_\_\_\_ mm  
 TST Read by: \_\_\_\_\_

RN, NP, PA or  
 Physician's Signature  
 Office Stamp \_\_\_\_\_

(If TST/Mantoux is positive, chest x-ray is required and report must be attached.)

Height \_\_\_\_\_ Weight \_\_\_\_\_  
 Blood Pressure \_\_\_\_\_  
 Vision: R \_\_\_\_\_ L \_\_\_\_\_ Corrected: R \_\_\_\_\_ L \_\_\_\_\_  
 Urinalysis: Micro \_\_\_\_\_ Sugar \_\_\_\_\_ Albumin \_\_\_\_\_  
 Hemoglobin (if indicated): \_\_\_\_\_ gms%

Is there loss or seriously impaired function of any paired organ? No  Yes

Recommendations for physical activity? Unlimited  Limited  Explain \_\_\_\_\_

Is the student taking any medication? No  Yes  Please list \_\_\_\_\_

I have examined the above patient and have found him/her physically fit to compete in intercollegiate sports. No  Yes

Have you any general comments? \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

PRINT NAME \_\_\_\_\_

ADDRESS & Office Stamp \_\_\_\_\_

**REQUIRED** →

**RETURN THIS FORM  
 IN ENVELOPE PROVIDED TO:  
 Director, Student Health and  
 Counseling Center  
 C.W. Post Campus  
 Long Island University  
 720 Northern Blvd.  
 Brookville, N.Y. 11548-1300  
 FAX: (516) 299-4113**

**\* PARENTAL/GUARDIAN PERMIT \***

The law requires that parental permission be obtained so that medical attention can be administered to minors. This consent should be signed by a parent or legal guardian so that procedures judged necessary may be conducted without undue delays. However, no major operation will be performed, except in extreme emergency, without the parents being contacted and fully informed.

I give my permission for such diagnostic and therapeutic procedures as may be deemed necessary for my son/daughter and also present information concerning his/her medical condition to other responsible College Officials when deemed necessary.

Signed \_\_\_\_\_ Relationship \_\_\_\_\_

Student is covered by: Hospitalization  Medical Care  Surgical Care

If yes, give company \_\_\_\_\_ Policy No. \_\_\_\_\_