



# Health History and Assessment

All Adelphi students must have a completed Health History and Assessment form on file in the Health Services Center prior to registration. If you have any questions, please contact the Center at (516) 877-6000. **Please complete all four pages of this form.**

All medical information will be maintained in confidence pursuant to the Educational Rights and Privacy Act of 1974.

## **PART I (To be completed by student or guardian.) PLEASE PRINT**

Last name \_\_\_\_\_ First name \_\_\_\_\_ Middle initial \_\_\_\_\_

Address \_\_\_\_\_  
Street Apartment City State Zip

Home telephone number ( ) \_\_\_\_\_ Social Security number \_\_\_\_\_ Birthdate \_\_\_\_\_

Cell phone number ( ) \_\_\_\_\_ Email address \_\_\_\_\_

## Emergency Contact

Name \_\_\_\_\_

Relationship \_\_\_\_\_ Telephone day ( ) \_\_\_\_\_ Telephone evening ( ) \_\_\_\_\_  
Area Code Area Code

## Consent for Medical Treatment

To provide medical treatment to students under the age of 18, parental permission is necessary by law. I hereby grant permission for medical evaluation, treatment, and hospitalization in case of accident or illness for myself/my son/my daughter. I also give permission for the release of information concerning my/his/her medical condition to other responsible University officials when necessary.

Signature of Student (if 18 or older)/Parent or Guardian (if student is a minor) \_\_\_\_\_

Date \_\_\_\_\_

## Consent for Mental Health Evaluation and Treatment

To provide mental health evaluation or treatment to students under the age of 18, parental permission is necessary by law. I hereby grant permission for mental health evaluation or treatment if necessary for my son/daughter.

Signature of Parent/Guardian (if student is a minor) \_\_\_\_\_

Date \_\_\_\_\_

Have you had any serious accidents, broken bones, or surgical operations?  No  Yes

If yes, please specify and provide dates: \_\_\_\_\_

Check any illnesses you have had and indicate month and year, if known (consult your physician if necessary).

- |   |           |   |           |   |           |
|---|-----------|---|-----------|---|-----------|
| <input type="checkbox"/> Frequent headaches   | ____/____ | <input type="checkbox"/> Pneumonia/pleurisy       | ____/____ | <input type="checkbox"/> Diabetes                 | ____/____ |
| <input type="checkbox"/> Epilepsy/convulsions | ____/____ | <input type="checkbox"/> Tuberculosis             | ____/____ | <input type="checkbox"/> Hypoglycemia             | ____/____ |
| <input type="checkbox"/> Thyroid dysfunction  | ____/____ | <input type="checkbox"/> Infectious mononucleosis | ____/____ | <input type="checkbox"/> Kidney/urinary infection | ____/____ |
| <input type="checkbox"/> Cancer               | ____/____ | <input type="checkbox"/> Allergy                  | ____/____ | <input type="checkbox"/> Hernia                   | ____/____ |

- |  |         |   |         |  |         |
|--|---------|---|---------|--|---------|
| <input type="checkbox"/> Asthma              | ___/___ | <input type="checkbox"/> Drug sensitivity               | ___/___ | <input type="checkbox"/> Heart disease       | ___/___ |
| <input type="checkbox"/> Anemia              | ___/___ | <input type="checkbox"/> Stomach/bowel difficulty       | ___/___ | <input type="checkbox"/> Scarlet fever       | ___/___ |
| <input type="checkbox"/> High blood pressure | ___/___ | <input type="checkbox"/> Hepatitis                      | ___/___ | <input type="checkbox"/> Skin disorders      | ___/___ |
| <input type="checkbox"/> Low blood pressure  | ___/___ | <input type="checkbox"/> Eye/ear/nose/throat infections | ___/___ | <input type="checkbox"/> Bone/joint disease  | ___/___ |
| <input type="checkbox"/> Rheumatic fever     | ___/___ | <input type="checkbox"/> Bleeding disorders             | ___/___ | <input type="checkbox"/> Menstrual disorders | ___/___ |

Do you have any physical (temporary or permanent) or emotional problems of which the University should be aware in order to assist you in the achievement of your educational goals?  Yes  No

If yes, please describe: \_\_\_\_\_

Are there any prescribed medications that you require on a regular basis?  Yes  No

If yes, please indicate type, dosage, and frequency: \_\_\_\_\_

## Family History

- |              |  |               |  |                |  |
|--------------|--|---------------|--|----------------|--|
| Diabetes     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Allergy/Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Anemia         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypertension  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood disease  | <input type="checkbox"/> Yes <input type="checkbox"/> No |

## PART II (To be completed and signed by physician.)

### Physician's Examination

Height \_\_\_\_\_ Nose \_\_\_\_\_ Thyroid \_\_\_\_\_  
 Weight \_\_\_\_\_ Mouth \_\_\_\_\_ Chest \_\_\_\_\_  
 Blood pressure \_\_\_\_\_ Tongue \_\_\_\_\_ Heart \_\_\_\_\_  
 Vision R \_\_\_\_\_ L \_\_\_\_\_ Teeth \_\_\_\_\_ Abdomen \_\_\_\_\_  
 Vision corrected R \_\_\_\_\_ L \_\_\_\_\_ Throat \_\_\_\_\_ Skin \_\_\_\_\_  
 Eyes \_\_\_\_\_ Pulse \_\_\_\_\_ Varicosities \_\_\_\_\_  
 Ears \_\_\_\_\_ Respirations \_\_\_\_\_ Reflexes \_\_\_\_\_  
 Mantoux (required 1 year prior to entrance) Date \_\_\_\_\_ Result \_\_\_\_\_  
*If the mantoux is positive, a chest x-ray is required and the report must be attached to this completed form.*  
 Routine urinalysis Date \_\_\_\_\_ Result \_\_\_\_\_  
 Previous medical history \_\_\_\_\_

In your judgment, is there any reason why physical education and/or athletic activities would be contraindicated?  Yes  No

If so, please explain. \_\_\_\_\_

### Recommended Immunizations

If there are valid reasons for non-compliance with state regulations, written proof on physician's stationery is required and must be attached to this completed form.

Chicken Pox	___/___/___	___/___/___	___/___/___	___/___/___
Whooping Cough	___/___/___	___/___/___	___/___/___	___/___/___
Polio	___/___/___	___/___/___	___/___/___	___/___/___
Tetanus Toxoid (within 10 yrs.)	___/___/___	___/___/___	___/___/___	___/___/___
Hepatitis B Series	___/___/___	___/___/___	___/___/___	___/___/___

**SEE NEXT PAGE FOR NEW YORK STATE MANDATED IMMUNIZATIONS →**

I have this day given \_\_\_\_\_ a careful examination and have found this person in \_\_\_\_\_ health.

Are you the family physician?  Yes  No How long have you known the applicant? \_\_\_\_\_

Physician's Name \_\_\_\_\_ Physician's Signature \_\_\_\_\_

Physician's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Registration Number \_\_\_\_\_ Date of Examination \_\_\_\_\_

**Physician Stamp Required**