# ADELPHI UNIVERSITY



PRE-COLLEGE PROGRAM STUDENT HEALTH AND EMERGENCY FORM 2017
PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS.

**THIS FORM MUST BE COMPLETED AND SUBMITTED TO THE OFFICE OF HIGH SCHOOL AND PRE-COLLEGE PROGRAMS BY JUNE 15, 2017.**

**PLEASE PRINT. (All information is required and all entries must be written in English.)**

Family name/surname ______________ First/given name ______________ MI ______

Nickname ______________

Home address ______________
Street Apt. City State Postal code

Date of birth ______________

Student home phone (   ) ______________ Student cellphone (   ) ______________

Student email ______________

Parent email ______________

## EMERGENCY CONTACT

Father's name ______________ Work phone no. ______________ Cellphone no. ______________

Mother's name ______________ Work phone no. ______________ Cellphone no. ______________

**Please provide the contact information of individuals who live near Garden City, New York, and who can travel to campus in an emergency.**

First emergency phone contact, notify ______________ Phone no. ______________

Second emergency phone contact, notify ______________ Phone no. ______________

Parent/guardian will be out of the country during the time the program is in session? ☐ Yes ☐ No

## FAMILY HEALTH INSURANCE INFORMATION*

Name of insured ______________ Relationship to participant ______________

Insurance company ______________ Group no. ______________

Policy number ______________ Member ID no. ______________

Primary healthcare provider name ______________

Phone no. ______________ Fax no. ______________

Address ______________

***Please provide a copy of front and back of insurance card(s) and pharmacy prescription card(s)**.

Adelphi University is not allowed to administer medications to any participant. The participant should be capable of self-administering the medication(s) or schedule the dose for before arrival or after departure.

**CONSENT FOR MEDICAL TREATMENT OF MINORS (students under the age of 18):**

To provide medical evaluation or treatment to students under the age of 18, parental permission is necessary by law. All students younger than 18 years old require a parent's or guardian's signature submitted to the Health Services Center for medical treatment consent.

I hereby grant permission for medical evaluation, treatment and hospitalization in case of accident or illness for my minor child/legal ward. I also give permission for the release of information concerning his or her medical condition to other responsible University officials when necessary, or to outside agencies for treatment on an as-needed basis.

Signature of parent/guardian ______________ Date ______________

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Family name/surname ______________________ First/given name ______________ MI ________

**SECTION 1** (Patient/parent or guardian is to complete Section 1.)

Drug allergies ______________________ Food allergies or intolerance ______________

Does student require EpiPen? ☐ Yes ☐ No Has student been trained in its use? ☐ Yes ☐ No ☐ NA

Medications (Please include prescription medications and any over-the-counter medications taken daily.):

______________________________________________

Past medical history ______________________________________________

______________________________________________

Family medical history ______________________________________________

______________________________________________

**SECTION 2: HEALTHCARE PROVIDER'S EXAMINATION** (to be completed by provider only)

Height ________ Weight ________ BMI ________ Blood pressure ______________ Heart rate ________

Vision R ________ L ________ (corrected or uncorrected) Hearing ____________ (whisper acceptable)

| System | Satisfactory | Unsatisfactory | Details if Unsatisfactory |
|---|---|---|---|
| HEENT | | | |
| Respiratory | | | |
| Cardiovascular | | | |
| Abdominal | | | |
| Genitourinary | | | |
| Musculoskeletal | | | |
| Skin | | | |
| Neurovascular | | | |

Student is cleared for all physical education and/or athletic activities. ☐ Yes ☐ No

If no, please explain why______________________________________________

Have you had any recent travel out of the country in the last 12 months? ☐ Yes ☐ No

**This section is mandatory for students in the Introduction to Nursing and Health Sciences programs or if the student lives outside of the United States.**
**PPD/Tuberclosis Test (Mantoux) or copy of lab work showing negative TB spot or quantification.**

Date and site placed ________ R or L forearm (Circle one.) Date read ________ Result (must include mm)

**If Mantoux is positive or lab test is positive at time of reading, a CXR must be done and the report attached with this form.**
**If student has history of previous positive Mantoux, include last CXR report (must be within five years) and treatment history.**

Healthcare provider's name ______________________ Date of exam ______________________

Signature ______________________ License no. ______________ Phone ______________

*This form will not be accepted without healthcare provider's signature and stamp, or license number if no stamp available.*

**This form must be returned to the Office of High School and Pre-College Programs, Hagedorn Hall, Room 201, One South Avenue, P.O. Box 701, Garden City, NY 11530-0701, USA or faxed to 516.877.3424.**