

Office of Summer and Intersession Programs One South Ave Garden City, NY 11530

P 516.877.3410 E precollege@adelphi.edu

Summer Pre-College Program Health History and Physical Examination Form

GENERAL INFORMATION	ON All information is required	and entries must be writte	en in English. Please print.			
Last Name	First Nam	MI				
Preferred Name DOB						
Home Address						
Home Phone ()	Cel	II Phone ()				
Email	Guardian	's Email				
EMERGENCY CONTACT	T (PARENT/GUARDIAN)					
1. Name	Relationship	Phone (_)			
2. Name	Relationship	Phone (
Please provide the name and conta emergency (if different than one or	act information of the individual who ca both of the student's guardian(s) listed (ın travel to Adelphi University's G above).	arden City campus in the case of an			
1. Name	Relationship	Phone ()			
Please check here if th	ne student's guardian(s) will be	out of the United States i	n part or for the entirety of the Program.			
HEALTH INSURANCE I	NFORMATION*					
Cardholder		Relationship				
Insurance Company		Group No.				
Policy No.		Member ID. No				
*Please provide a copy of the from	nt and back of the insurance card and	d pharmacy prescription card a	long with this completed form.			
Name of Primary Healtho	care Provider					
Phone ()	Fax	< ()				
Address						
Note: University faculty and staff ca medication(s) or schedule the dose f	nnot administer medications to any stu for before arrival to or after departure f	dent. The student should be cap from the Program.	able of self-administering the			
CONSENT FOR MEDICA	L TREATMENT OF MINO	RS (Students Under th	ne Age of 18)			
To provide medical evaluation or tre parent's or guardian's signature subr	atment to minors, permission is necess mitted to the Health Services Center for	ary by law. All students under th medical treatment consent.	e age of 18 years old require a			
my minor child/legal ward	d. I also give permission for t	he release of informati	cion in case of accident or illness for on concerning my student's medical de agencies for treatment on an as-			
Name	Signature		Date			

SECTION 1: MEDICAL HISTORY (To be Completed by Parent/Guardian) Drug Allergies Food Allergies/Intolerance Other Dietary Restrictions/Needs Student Requires EpiPen? YES NO Student Trained in Use? N/A YES NO Medications (Please Include ALL Prescription Medications and Over-the-Counter Medications Taken Daily) Past Medical History Farnily Med	Last Name		First Name	MI	
Cool Allergies/Intolerance Dether Dietary Restrictions/Needs Student Requires EpiPen?YES NO Student Trained in Use? N/AYES NO Medications (Please Include ALL Prescription Medications and Over-the-Counter Medications Taken Daily)	SECTION 1: MEDI	CAL HISTORY (To be	e Completed by Parent/G	uardian)	
Student Requires EpiPen? YES NO Student Trained in Use? N/A YES NO Medications (Please Include ALL Prescription Medications and Over-the-Counter Medications Taken Daily) Past Medical History Family Medical History Famil	Orug Allergies				
Addications (Please Include ALL Prescription Medications and Over-the-Counter Medications Taken Daily) Past Medical History Family Medical History Fravelled Out of the United States in the Last 12 Months? Yes No SECTION 2: HEALTHCARE PROVIDER'S EXAMINATION ITO be Completed by Provider ONLY) Height Weight BMI Blood Pressure Heart Rate //sion R L (Corrected/Uncorrected) Hearing (Whisper Acceptable) SYSTEM SATISFACTORY UNSATISFACTORY DETAILS IF UNSATISFACTORY HEENT Respiratory	ood Allergies/Into	olerance			
Past Medical History	Other Dietary Rest	rictions/Needs			
Past Medical History Family Medical History Fravelled Out of the United States in the Last 12 Months?	Student Requires	EpiPen? YES	NO Student Trained in	Use? N/A YE	S NO
Family Medical History	Medications (<i>Please</i>	Include ALL Prescription	on Medications and Over-the	-Counter Medications Taken	Daily)
Travelled Out of the United States in the Last 12 Months?	Past Medical Histo	ory			
SECTION 2: HEALTHCARE PROVIDER'S EXAMINATION (To be Completed by Provider ONLY) Height	-amily Medical His	story			
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Cardiovascular Abdominal Genitourinary Musculoskeletal Skin Neurovascular Cleared for Physical Activities? Yes No *If no, please explain SECTION 3: TUBERCULOSIS TEST (MANDATORY for international AND Intro to Nursing students) Tuberculosis testing is mandatory for all international students and Introduction to Nursing students. For international students or those who may have received the BCG vaccine, the T-Spot.TB (PREFERRED) or QuantiFERON blood test is required. TST (PPD): Date Placed R L Forearm (Circle One) Date Read Result (in MM)* PPD Test Result: POSITIVE NEGATIVE (Circle/Check One) T-Spot.TB/QuantiFERON Result*: (Must Include Copy of Lab Test with Completed F *All positive tests require a chest x-ray within the last five years. A copy of the x-ray results must be included. Healthcare Provider's Name Date of Exam Date of Exam		SATISFACTORT	UNSATISFACTURI	DETAILS IF UNSATIS	FACTORT
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	*All positive tests require	a chest x-ray within the last f	ive years. A copy of the x-ray results n	nust be included.	
Signature Phone	Healthcare Prov	ider's Name		Date of Exam	
	Signature		License No.*	Phone	
STAMP HERE					

^{*}This form will NOT be accepted without the healthcare provider's signature and stamp or license number if no stamp is available.