



Office of Summer and Intersession Programs  
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## Summer Pre-College Program Health History and Physical Examination Form

**GENERAL INFORMATION** All information is required and entries must be written in English. Please print.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Preferred Name \_\_\_\_\_ DOB \_\_\_\_\_

Home Address \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email \_\_\_\_\_ Guardian's Email \_\_\_\_\_

### EMERGENCY CONTACT (PARENT/GUARDIAN)

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

2. Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

*Please provide the name and contact information of the individual who can travel to Adelphi University's Garden City campus in the case of an emergency (if different than one or both of the student's guardian(s) listed above).*

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_ Please check here if the student's guardian(s) will be out of the United States in part or for the entirety of the Program.

### HEALTH INSURANCE INFORMATION\*

Cardholder \_\_\_\_\_ Relationship \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_

Policy No. \_\_\_\_\_ Member ID. No. \_\_\_\_\_

**\*Please provide a copy of the front and back of the insurance card and pharmacy prescription card along with this completed form.**

Name of Primary Healthcare Provider \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address \_\_\_\_\_

*Note: University faculty and staff cannot administer medications to any student. The student should be capable of self-administering the medication(s) or schedule the dose for before arrival to or after departure from the Program.*

### CONSENT FOR MEDICAL TREATMENT OF MINORS (Students Under the Age of 18)

*To provide medical evaluation or treatment to minors, permission is necessary by law. All students under the age of 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 my student's medical condition to other responsible University officials when necessary or to outside agencies for treatment on an as-needed basis.

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

**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 \_\_\_\_\_

Family Medical History \_\_\_\_\_

Travelled Out of the United States in the Last 12 Months? \_\_\_\_\_ Yes \_\_\_\_\_ No

**SECTION 2: HEALTHCARE PROVIDER'S EXAMINATION** (To be Completed by Provider ONLY)

Height \_\_\_\_\_ Weight \_\_\_\_\_ BMI \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Heart Rate \_\_\_\_\_

Vision R \_\_\_\_\_ L \_\_\_\_\_ (Corrected/Uncorrected) Hearing \_\_\_\_\_ (Whisper Acceptable)

SYSTEM	SATISFACTORY	UNSATISFACTORY	DETAILS IF UNSATISFACTORY
HEENT			
Respiratory			
Cardiovascular			
Abdominal			
Genitourinary			
Musculoskeletal			
Skin			
Neurovascular			

Cleared for Physical Activities? \_\_\_\_\_ Yes \_\_\_\_\_ No \*If no, please explain. \_\_\_\_\_

**SECTION 3: TUBERCULOSIS TEST** (MANDATORY for International AND Nursing/Science, Medicine and Health Students)

*Tuberculosis testing is mandatory for all international students and students entering into health-related clinical sites (Nursing and Science, Medicine and Health 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 Form)

*\*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 \_\_\_\_\_

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.**