ADELPHI UNIVERSITY
Office of Summer and Intersession Programs
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Garden City, NY 11530
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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 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 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.***