NAME: _____

LAST FIRST M.I.

C.W. POST CAMPUS OF LONG ISLAND UNIVERSITY

REPORT OF MEDICAL HISTORY

ALL STUDENTS MUST COMPLETE THIS FORM

Student: Please complete this page before going to your physician for examination.

SOCIAL SECURITY NO. / I.D. NO. | DATE OF BIRTH | SEX (M F) | E-MAIL | CELL PHONE NUMBER

HOME ADDRESS (Number & Street) | CITY OR TOWN | STATE/COUNTRY | ZIP CODE | HOME TELEPHONE NO.

NAME & ADDRESS OF EMERGENCY CONTACT | RELATIONSHIP | HOME TELEPHONE NO. | BUSINESS TELEPHONE NO.

FAMILY HISTORY

	AGE	STATE OF HEALTH	OCCUPATION	AGE OF DEATH	CAUSE OF DEATH
Father					
Mother					
Brother(s)					
Sister(s)					

Have any of your relatives had any of the following?

	YES	NO	RELATIONSHIP
Tuberculosis			
Diabetes			
Kidney Disease			
Heart Disease			
Arthritis			
Stomach Disease			
☐ Asthma ☐ Hay Fever			
☐ Epilepsy ☐ Convulsions			

PERSONAL HISTORY

HAVE YOU HAD:	Yes	No		Yes	No		Yes	No		Yes	No
Scarlet Fever			Insomnia			**Chest**			Gallbladder Trouble		
Measles			Frequent Anxiety			☐ Pain ☐ Pressure			or Gallstones		
German Measles			Frequent Depression			Chronic Cough			Recurrent Diarrhea		
Mumps			Worry or Nervousness			Palpitations (Heart)			☐ Rupture ☐ Hernia		
Chicken Pox			Recurrent Headaches			High Blood Pressure			Recent Weight:		
Malaria			Recurrent Colds			Low Blood Pressure			☐ Gain ☐ Loss		
☐ Gum ☐ Tooth Trouble			Head Injury with Unconsciousness			Rheumatic Fever			☐ Dizziness ☐ Fainting		
Sinusitis						Heart Murmur			☐ Weakness ☐ Paralysis		
Eye Trouble			☐ Hay Fever ☐ Asthma			Joint Problems:			☐ Epilepsy ☐ Convulsions		
☐ Ear ☐ Nose			Tuberculosis			Trick Knee			URINE: Sugar		
☐ Throat Trouble			Shortness of Breath			Shoulder			Albumin		
Surgery			**Allergy**			Back Problems			Frequent Urination		
Appendectomy			Penicillin			☐ Tumor ☐ Cancer ☐ Cyst			Smoker - how many per day:		
Tonsillectomy			Sulfonamides			Jaundice			**FEMALES ONLY**		
Hernia Repair			Serum			Stomach Trouble			Irregular Periods		
Other			Foods (which)			Intestinal Trouble			Severe Cramps		
			Other			☐ Diabetes ☐ Hypoglycemia			Excessive Flow		

	Yes	No
A Has your physical activity been restricted during the past five years? (Give reasons and duration)		
B Have you had difficulty with school or teachers? (Give details)		
C Have you received treatment or counseling for a nervous condition, emotional problems, or substance abuse problems? (Give details)		
D Have you had any illness or injury or been hospitalized other than already noted? (Give details)		
E Have you consulted or been treated by clinics, physicians, healers or other practitioners within the past five years? (Other than routine checkups?)		

CHECK IF ANY APPLY:

_____ Wheelchair bound _____ Deaf

_____ Use of braces or crutches _____ Hearing impaired

_____ Blind _____ Other handicap

_____ Visually impaired

Please briefly explain your special needs: _____

ADDITIONAL COMMENTS

RETURN THIS FORM IN ENVELOPE PROVIDED TO:
Director, Student Health and Counseling Center
C.W. Post Campus
Long Island University
720 Northern Blvd.
Brookville, N.Y. 11548-1300
FAX: (516) 299-4113

STUDENT AFFIDAVIT: I hereby certify that all the information entered is complete & accurate:

Student Signature: _____ Date _____

C.W. POST CAMPUS

LONG ISLAND UNIVERSITY

REPORT OF HEALTH EVALUATION

TO BE COMPLETED ONLY BY PHYSICIAN, PA OR NP

To the Examining Healthcare Provider: Please review the student's history and complete the form below. Comment on all positive answers. The information supplied will not affect his/her status; it will be used only as a background for providing health care if necessary. This information is strictly for the use of the Student Health and Counseling Center and will not be released without student consent. Please be sure to sign both sides of form.

M ☐ F ☐

STUDENT'S LAST NAME | FIRST NAME | MIDDLE | SEX

STUDENT'S SOCIAL SECURITY NUMBER | ☐ RESIDENT | ☐ COMMUTER | DATE OF BIRTH

MANDATED BY NEW YORK STATE LAW

New York State requires all students attending its colleges and universities in New York state who were born on or after **JANUARY 1, 1957**, to be immunized against **Measles, Mumps and Rubella.** Records should indicate **TWO** immunizations against **Measles** and **ONE** each against **Mumps and Rubella**. All immunizations must have been live vaccines – measles available **in 1968** and mumps available **in 1968**. All immunizations must have been given on or after the first birthday

IMMUNIZATIONS - Please give complete dates (Month/Day/Year)

	Date(s) of Immunization			Date of Disease	Titre*
MMR	1st	2nd			*MUST attach
Rubeola	1st	2nd			a copy of
Mumps					actual lab
Rubella				NOT acceptable	report
Menomune/Menactra					
Polio					
Tetanus Toxoid					
HBV	1st	2nd	3rd		

I HAVE EXAMINED THE FOLLOWING:

	FINDINGS:
1. Head, Ears, Nose & Throat	
2. Respiratory	
3. Cardiovascular	
4. Gastrointestinal	
5. Hernia(s)	
6. Eyes	
7. Genitourinary	
8. Musculoskeletal	
9. Metabolic/Endocrine	
10. Neuropsychiatric	
11. Skin	

TST I.D. (Mantoux) **Mandatory**

Date administered: _____

Date read: _____ Results _____mm

TST Read by: _____

Physician's Signature and Office Stamp _____

(If TST/Mantoux is positive, chest x-ray is required and report must be attached.)

Height _____ Weight _____

Blood Pressure _____

Vision: R _____ L _____ Corrected: R _____ L _____

Urinalysis: Micro _____ Sugar _____ Albumin _____

Hemoglobin (if indicated): _____ gms%

Is there loss or seriously impaired function of any paired organ? No ☐ Yes ☐ _____

Recommendations for physical activity? Unlimited ☐ Limited ☐ Explain _____

Is the student taking any medication? No ☐ Yes ☐ Please list _____

I have examined the above patient and have found him/her physically fit to compete in intercollegiate sports. No ☐ Yes ☐

Have you any general comments? _____

Physician's Signature _____ Date _____

PRINT NAME _____

ADDRESS & Office Stamp _____

REQUIRED

RETURN THIS FORM IN ENVELOPE PROVIDED TO:
Director, Student Health and Counseling Center
C.W. Post Campus
Long Island University
720 Northern Blvd.
Brookville, N.Y. 11548-1300
FAX: (516) 299-4113

PARENTAL/GUARDIAN PERMIT

The law requires that parental permission be obtained so that medical attention can be administered to minors. The following consent form should be signed by a parent or legal guardian so that procedures judged necessary may be conducted without undue delays. However, no major operation will be performed, except in extreme emergency, without the parents being contacted and fully informed.

I give my permission for such diagnostic and therapeutic procedures as may be deemed necessary for my son/daughter and also present information concerning his/her medical condition to other responsible College Officials when deemed necessary.

Signed _____ **Relationship** _____

Student, please attach a copy of both sides of your valid health insurance card.

Rev. 05/10 (hlthfrm2)