REPORT OF HEALTH EVALUATION

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. This information is strictly for the use of LIU Post Medical Services and will not be released without written student consent. **Please be sure to date, sign and stamp form.**

M ☐ F ☐

STUDENT'S LAST NAME FIRST NAME MIDDLE SEX

STUDENT'S ID / SS # WILL YOU BE LIVING ON CAMPUS? ■ YES ■ NO DATE OF BIRTH

TO BE COMPLETED ONLY BY PHYSICIAN, PA OR NP

MANDATED BY NEW YORK STATE LAW

New York State requires all students attending its colleges and universities who were born on or after **JANUARY 1, 1957**, to be immunized against **Measles, Mumps and Rubella. TWO** immunizations against **Measles** and **ONE** each against **Mumps and Rubella** are required. All immunizations must have been live vaccines.

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

	Date(s) of Immunization			Date of Disease	Titre*
MMR	1st	2nd			*MUST attach
MMR Vz	1st	2nd			a copy of
Varicella	1st	2nd			actual laboratory
Rubeola					report for any
Mumps					titre result(s)
Rubella				NOT acceptable	
Menomune Menactra Menveo					
Polio					
Tetanus					
HBV	1st	2nd	3rd		

I HAVE EXAMINED:	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: _____ Site: _____ Wheal: _____ mm

Date read: _____ Results _____ mm

Read by: _____ RN NP PA MD DO

Office Stamp _____

(*If positive, blood test (i.e. TSpotTB) is required and report attached.)

Height _____ Weight _____ BP _____

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, Medical Services
JPLI
P.O Box 5482 Bay Shore
N.Y. 11706 U.S.A
E-mail: esl@jpli.org
Phone: 1-866-735-3555

*** PARENTAL/GUARDIAN PERMIT ***

The law requires that parental permission be obtained so that medical attention can be administered to minors. This consent 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** _____

PLEASE ATTACH A COPY OF BOTH SIDES OF STUDENT'S HEALTH INSURANCE CARD.

Rev. 02/13 (hlthfrm2)