

## HEALTH EVALUATION FORM

Please complete this form accurately with your physician and mail it with the immunization form to **PrattMWP Student Health Center**. Information supplied is part of your health record; it will be held in **STRICT CONFIDENCE** at the Student Health Center. This information in no way impacts your academic standing at the Institute. This form **MUST** be returned to PrattMWP prior to the start of classes. We ask that this form be mailed to the Health Center by August 1.

<b>Last Name:</b> _____	<b>First Name:</b> _____	<b>Middle:</b> _____
<b>Date of Birth:</b> ____/____/____	<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>SS#:</b> ____ - ____ - ____
<b>Home Address:</b> _____		
<b>City:</b> _____	<b>State:</b> _____	<b>Zip:</b> _____
<b>Home Phone Number:</b> (     )     -     _____	<b>Cell/Alternate:</b> (     )     -     _____	

<b>Person to be notified in the event of an emergency:</b>	
Name: _____	Relationship to you: _____
Address: _____	
Home Phone Number: (     )     -     _____	Cell/Alternate: (     )     -     _____

<b>Consent:</b> I consent to medical treatment by the staff at the PrattMWP Student Health Center, consulting and referred physicians, emergency medical technicians, and counselors.		
Student Signature _____	Date _____	Parent/ Guardian Signature (if under 18) _____

<b>Family History:</b> Which blood relative has/ had the following medical treatment?		
Cancer: _____	Type: _____	Tuberculosis: _____
Hepatitis: _____	Type: _____	Diabetes: _____
Heart Disease: _____	Type: _____	Substance Abuse: _____
Kidney Disease: _____		Mental Illness: _____
High Blood Pressure: _____		Other Heredity Disease: _____

<b>Personal Health History:</b> Please check if you ever had or presently have the following:			
<input type="checkbox"/> Anemia	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Gallbladder trouble	<input type="checkbox"/> Appendix removed
<input type="checkbox"/> Chronic cough	<input type="checkbox"/> Gum or Tooth trouble	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cysts/ tumors
<input type="checkbox"/> Headaches/severe	<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Head injury
<input type="checkbox"/> Back problems	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Blood clotting problems
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Bone/ Joint Disease	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Ear/ Nose Problem
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Eye/ Vision Problems	<input type="checkbox"/> Hernia
<input type="checkbox"/> Cancer	<input type="checkbox"/> Fainting Spells	<input type="checkbox"/> Stomach Problems	<input type="checkbox"/> Chest pain/ Pressure
<input type="checkbox"/> Foot Problems	<input type="checkbox"/> Intestinal Problems	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Tonsils Removed	<input type="checkbox"/> Loss of extremity	<input type="checkbox"/> Malaria	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Sickle Cell Anemia	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Urinary Problems	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Skin disorder
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Strep throat	<input type="checkbox"/> Whooping cough	<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Pleurisy	<input type="checkbox"/> HIV+	<input type="checkbox"/> Sexually Transmitted Disease: _____	

Religion/ Denomination: \_\_\_\_\_

Do you have any religious observances that restrict or impact medical treatment options?  Yes  No

Has your physical activity been restricted in the past 5 years?  Yes  No

If Yes, please explain.

Please describe any major hospitalization or surgery:

Do you have any allergies?  Yes  No

If Yes, please explain.

Do you take any medications regularly, including vitamins?  Yes  No

If Yes, please explain.

**\*For Women Only\*** Please check if you suffer from the following:

- Irregular Periods       Severe Cramps       Excessive Bleeding       No Periods       PMS  
 Other Gynecological Problems:

### EMOTIONAL and MENTAL HEALTH

• Have you ever used psychological counseling services?  Yes  No

• Are you currently using psychological counseling services?  Yes  No

○ Diagnosis: \_\_\_\_\_

• Have you ever been hospitalized for emotional difficulties or mental health?  Yes  No

○ Diagnosis: \_\_\_\_\_

○ Length of time in hospital: \_\_\_\_\_

• Have you ever taken medication to help with psychological issues?  Yes  No

○ Was this medication helpful?  Yes  No

○ If Yes what medication was prescribed? \_\_\_\_\_

• If you are currently taking psychotropic medication do you plan to continue taking this medication while you are enrolled at PrattMWP?  Yes  No

○ Please list medication(s) here: \_\_\_\_\_

○ How do you plan to obtain medications while enrolled at PrattMWP?

**Please check if you have experienced any of the following:**

- General Adjustment Issues       Anxiety Disorders       Eating Disorder       Mood Swings  
 Family Issues       Sleep Disorders       Dependency       Substance Abuse  
 Sexual Abuse/ Assault       Depression       Addictions       Other:

**Is there any additional or pertinent information or special needs that our medical and counseling staff need to be aware of so that we can better meet your needs at PrattMWP?**

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## PHYSICAL EXAM

The following section is to be completed by your physician. The exam must be within one year prior to enrollment at PrattMWP.

<b>Physical Exam Date:</b> ____/____/____		
<b>Last Name:</b> _____	<b>First Name:</b> _____	<b>Middle:</b> _____
<b>Date of Birth:</b> ____/____/____		<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female

<b>Height:</b> Feet: ____ Inches: ____	<b>Weight:</b> ____ lbs.	<b>Pulse:</b> ____ per min.	<b>Blood Pressure:</b> _____
<b>Hearing:</b> R ____ L ____	<b>Hearing Aid:</b> _____		
<b>Vision:</b> Uncorrected: R ____ L ____		Corrected: R ____ L ____	Glasses ____ Contact Lenses _____

**Please comment on all of the following:**

<b>Skin</b>	
<b>HEENT</b>	
<b>Lungs/ Chest</b>	
<b>Breasts</b>	
<b>Heart/ Vascular System</b>	
<b>Abdomen</b>	
<b>Genito-urinary</b>	
<b>Pelvic</b>	
<b>Muscular/ Skeletal</b>	
<b>Neurological</b>	
<b>Endocrine</b>	
<b>Psychiatric</b>	

<b>CBC:</b>	<b>Urinalysis:</b>	Sp. Gravity	Protein
		Sugar	Micro

Is there any medication/ vitamin/ OC that this student takes regularly or routinely?  Yes  No  
Please list:

General appraisal of health:

I certify that I have on this date examined this student and that, on the basis of the examination requested by the college authorities and the student's medical history as furnished to me, I have found no reason that would make it medically inadvisable for this student to participate in supervised athletic activities, except those checked below:

- Soccer   
  Weight Lifting   
  Yoga   
  Aerobics   
  Martial Arts   
  Other: \_\_\_\_\_

**Physician/ Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Physician/ Provider Printed Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

## IMMUNIZATION RECORD FORM

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

This form **MUST** be **COMPLETED** and **SIGNED** by a health care provider. *Information must be recorded in English and listed by month, day, and year.* **New York State Public Health Law 2165 REQUIRES proof of two measles, one mumps, and one rubella immunization on or after the first birthday.**

A) This student was born before January 1, 1957 and therefore is considered immune to measles, mumps, and rubella. \_\_\_\_\_

### REQUIRED IMMUNIZATIONS

**B) M.M.R.** (Measles, Mumps, Rubella) administered instead of individual immunizations.

1) Dose 1- Immunized at 12 months or after: (Date- Month, Day, Year) \_\_\_\_/\_\_\_\_/\_\_\_\_  
 2) Dose 2- Immunized at least 1 month later: (Date- Month, Day, Year) \_\_\_\_/\_\_\_\_/\_\_\_\_

**C) MEASLES** (Rubeola) Immunity. (*Check all that apply*)

1) TWO dates of Measles Immunizations. Dose 1: (Date- Month, Day, Year) \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Dose 2: (Date- Month, Day, Year) \_\_\_\_/\_\_\_\_/\_\_\_\_  
 2) Dates of Measles Titer: (Date- Month, Day, Year) \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Results: Laboratory Results Enclosed: \_\_\_\_\_  
 3) Date of physician diagnosed measles disease: (Date- Month, Day, Year) \_\_\_\_/\_\_\_\_/\_\_\_\_

**D) RUBELLA** (German Measles) Immunity. (*Must have one of the following*)

**Physician diagnosis is not acceptable for Rubella immunity.**

1) Date of Rubella Immunization. (Date- Month, Day, Year) \_\_\_\_/\_\_\_\_/\_\_\_\_  
 2) Dates of Rubella Titer: (Date- Month, Day, Year) \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Results: Laboratory Results Enclosed: \_\_\_\_\_

**E) MUMPS** Immunity. (*Must have one of the following*)

1) Date of Mumps Immunizations. (Date- Month, Day, Year) \_\_\_\_/\_\_\_\_/\_\_\_\_  
 2) Dates of Measles Titer: (Date- Month, Day, Year) \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Results: Laboratory Results Enclosed: \_\_\_\_\_  
 3) Date of physician diagnosed measles disease: (Date- Month, Day, Year) \_\_\_\_/\_\_\_\_/\_\_\_\_

**F) TUBERCULOSIS:** (*PPD required regardless of prior BCG inoculation*)

1) PPD (Mantoux) test within the past 12 months (*Tine or Momovac are not acceptable*) **NO SELF READS.**  
 Date of test: \_\_\_\_/\_\_\_\_/\_\_\_\_ Results: \_\_\_\_ mm in duration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 2) If GREATER than 10 mm in duration, CHEST X-ray is REQUIRED.  
 Date of X-ray: \_\_\_\_/\_\_\_\_/\_\_\_\_ Results: \_\_\_\_\_  
 3) Treated with INH:  Yes  No Duration: \_\_\_\_\_ months. Was treatment completed?  Yes  No  
 4) Received BCG vaccine:  Yes  No. If YES, when? (Date- Month, Day, Year) \_\_\_\_/\_\_\_\_/\_\_\_\_

**G) POLIO:** (*Completed primary series of Polio Immunization*) (Date- Month, Day, Year) \_\_\_\_/\_\_\_\_/\_\_\_\_

**H) TETANUS-DIPHTHERIA** (*Primary series with DtaP or DTP and booster with Td in the last 10 years, meets requirement*)

1) Date of Tetanus-Diphtheria Booster within the last 10 years. (Date- Month, Day, Year) \_\_\_\_/\_\_\_\_/\_\_\_\_

**I) MENINGITIS: NYS Public Health Law 2167. Please refer to enclosed information regarding Meningitis and complete form.**

1) Date of Meningitis vaccine (*Menomune*) (Date- Month, Day, Year) \_\_\_\_/\_\_\_\_/\_\_\_\_  
 2) Complete, sign, and return the enclosed Meningitis Response form.

### RECOMMENDED IMMUNIZATIONS

**K) HEPATITIS B** #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ #2 \_\_\_\_/\_\_\_\_/\_\_\_\_ #3 \_\_\_\_/\_\_\_\_/\_\_\_\_  
**L) HEPATITIS A** #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ #2 \_\_\_\_/\_\_\_\_/\_\_\_\_  
**M) VARICELLA** (*Chicken Pox*) #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ #2 \_\_\_\_/\_\_\_\_/\_\_\_\_

### HEALTH CARE PROVIDER INFORMATION

NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_  
 SIGNATURE: \_\_\_\_\_ PHONE #: \_\_\_\_\_