

Please Return to:
 STATE EDUCATION DEPARTMENT
 New York State Summer Institutes
 89 Washington Avenue, Room 866 EBA
 Albany, NY 12234
 (518) 474-8773

Health Assessment

PART 1.

(To be completed and submitted with Health Assessment PART 2.)

Please check School(s) attending			
<input type="checkbox"/>	Ballet	<input type="checkbox"/>	Media Arts
<input type="checkbox"/>	Choral Studies	<input type="checkbox"/>	Orchestral
<input type="checkbox"/>	Dance	<input type="checkbox"/>	Theatre
<input type="checkbox"/>	Jazz	<input type="checkbox"/>	Visual Arts

Personal Information

1. NAME OF STUDENT (Last, First, Middle Initial)			
2. DATE OF BIRTH	3. AGE	4. COUNTY OF RESIDENCE	5. GENDER <input type="checkbox"/> Female <input type="checkbox"/> Male
6. ADDRESS (Street, City, State, Zip Code)			

Parent/Guardian Information

7. NAME OF PARENT/GUARDIAN (Last, (First, Middle Initial)	
8. ADDRESS (Street, City, State, Zip Code)	
9. HOME TELEPHONE NUMBER (Include Area Code)	10. BUSINESS TELEPHONE NUMBER (Include Area Code)
11. CELL PHONE (Include Area Code)	12. OTHER (pager, email address, fax)

PARENT/GUARDIAN: PLEASE LIST PERSON(S) TO CONTACT IN AN EMERGENCY IF YOU CANNOT BE LOCATED

13. NAME (Last, First, Middle Initial)	14. RELATIONSHIP
15. ADDRESS (Street, City, State, Zip Code)	
16. HOME TELEPHONE NUMBER (Include Area Code)	17. BUSINESS TELEPHONE NUMBER (Include Area Code)

Insurance Information

18. INSURANCE CO:	19. INSURED'S NAME (Last, First, Middle Initial)	
20. ADDRESS (Street, City, State, Zip Code)	21. TELEPHONE NUMBER (Include Area Code)	
22. INSURED'S SS #	23. POLICY #	24. GROUP #

THIS PART MUST BE SIGNED AND NOTARIZED

I, _____ pursuant to the authority vested in me as parent or guardian of _____ do hereby authorize the College Health Service, the New York State Summer Institutes, and/or (medical facility to be inserted in blank space at time of treatment) _____, upon Consultation with a practicing physician or surgeon, to exercise for me on my behalf all my rights and duties with reference to consenting to appropriate medical and surgical treatment, anesthetics, medicines and hospitalization, including care and treatment by the hospital which they may deem necessary for emergency care. Furthermore, I, the undersigned, will assume full responsibility for all medical costs incurred by my child not covered by medical insurance or normally provided by the College Health Services. Additionally, I give permission for my child to receive the necessary immunizations to fulfill requirement stated on Health Assessment, Part 2.

Signed: _____ Date: _____

Subscribed before me this _____ day of _____

Notary Public

Seal

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HEALTH ASSESSMENT PART 2.

(To be completed by physician)

NAME OF STUDENT (Last, First, Middle Initial) _____

25. DATE OF LAST PHYSICAL EXAMINATION _____ 26. WEIGHT _____ 27. HEIGHT _____

28. BLOOD PRESSURE _____ 29. VISION _____ 30. HEARING _____

31. MEDICAL HISTORY

<input type="checkbox"/> Asthma	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Malignancy	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Eczema	<input type="checkbox"/> Injuries	<input type="checkbox"/> Menstrual cramps	<input type="checkbox"/> Seasonal allergy
<input type="checkbox"/> Chronic intestinal problems	<input type="checkbox"/> Emotional instability	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Operations	<input type="checkbox"/> Sleep disorder
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Lung problems	<input type="checkbox"/> Orthopedic problems	<input type="checkbox"/> Tuberculosis or TB Contact

Drug and/or Food Allergy (specify) _____

32. LIST ALL PAST MEDICAL PROBLEMS AND RELATED TREATMENTS:

None

33. LIST ALL CURRENT MEDICAL CONDITIONS:

None

34. LIST ALL MEDICATIONS CURRENTLY BEING TAKEN WITH DOSAGE, FREQUENCY AND CONDITION FOR WHICH IT IS BEING TAKEN:

MEDICATIONS	DOSAGE	FREQUENCY	CONDITION

35. PLEASE LIST ANY ALLERGIES

36. DOES THE PARTICIPANT HAVE ANY SIGNIFICANT FINDINGS ON PHYSICAL EXAM? YES (Specify) NO

Immunizations (Fill in dates mm/dd/yyyy)

37. DIPHTHERIA AND TETANUS TOXOIDS (or Diphtheria, Tetanus Toxoids and Pertussis Vaccine) (dates) _____

38. ORAL POLIOMYELITIS VACCINE **OR** INACTIVATED POLIO VACCINE (Dates) _____

39. MEASLES (Rubeola) Must have 2 Measles or MMR injections, both AFTER FIRST BIRTHDAY AND AT LEAST 30 DAYS APART, if you were born after 1957

40. Primary Measles **OR** MMR immunization (date) _____ Most Recent Booster (date) _____

41. MUMPS (date) _____ 42. RUBELLA (German Measles) (date) _____

43. VARICELLA (Date Chicken Pox was diagnosed): _____ **OR** Date(s) of VARIVAX VACCINE _____

44. HEPATITIS B VACCINE (date) _____

45. **MENINGOCOCCAL MENINGITIS IMMUNIZATION (Menomune™)**
 Vaccinated within the past 10 years (date) _____ **OR**
 Parent/guardian has read, or I have had explained to them, the information regarding meningococcal meningitis disease. Parent/guardian understands the risks of not receiving the vaccine. Parent/guardian has decided that the child will not obtain immunization against meningococcal meningitis disease. (Parent/guardian signature) _____

46. OTHER IMMUNIZATIONS: (specify type & Date) _____

47. TB SCREENING

a. Does the participant have signs or symptoms of active TB? Yes No
 If no, proceed to question b. If yes, proceed with additional evaluation to exclude active TB disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.

b. Is the participant a member of a high-risk group? Yes No **If no, stop.** No further evaluation is needed at this time. If yes, place tuberculin skin test (Mantoux only). A history of BCG vaccination should not preclude testing of a member of a high-risk group. If there is a history of a past positive PPD, proceed to question d.

c. Tuberculin Skin Test (required within 6 months of Program, **if needed after above screening**).
 Date given: (mm/dd/yyyy) _____ Date read: (mm/dd/yyyy) _____
 Result _____ Record actual mm of induration, transverse diameter, if no induration write "0"
 Interpretation (based on mm of induration as well as risk factors): Positive Negative

d. Chest x-ray (required within 6 months of Summer Program if tuberculin skin test is positive).
 Result: Normal Abnormal Date of x-ray: (mm/dd/yyyy) _____

I have performed a physical examination on this patient within the past year. All medical/psychiatric conditions and therapies are noted above or on attached pages. She/he may participate in the Summer Program without restrictions.

Exceptions (if any) _____ Date _____

Signature _____ Print Name _____