DAEMEN COLLEGE

STUDENT'S REPORT OF MEDICAL HISTORY
COMPLETE THIS BEFORE GOING TO YOUR HEALTH CARE PROVIDER FOR EXAMINATION

NAME _____
(PRINT) Last First Middle

DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____

SEX: ❒ MALE ❒ FEMALE MARITAL STATUS: ❒ MARRIED ❒ SINGLE ❒ OTHER

HOME ADDRESS _____
Number and Street City or Town State Zip Code

_____ _____
Home Telephone Number with Area Code Cell Phone Number with Area Code

PERSON TO BE NOTIFIED IN EMERGENCY _____
Name and Relationship

_____ _____
Home Telephone with Area Code Business Telephone with Area Code

HEALTH CARE PROVIDER _____
Name Telephone Number with Area Code

ADDRESS _____
Number, Street, City, State, and Zip

MANDATORY Health Insurance Information:
NAME OF INSURANCE COMPANY: _____

POLICY #: _____ ID#: _____ GROUP #: _____

IMMUNIZATIONS

MMR 1 _____ MMR 2 _____ OR DATES:

26. Measles: ❒ 2 doses vaccine _____
_____
or ❒ pos. serologic test _____
(attach lab report)

27. Mumps: ❒ mumps vaccine _____
or ❒ pos. serologic test _____
(attach lab report)

28. Rubella: ❒ rubella vaccine _____
or ❒ pos. serologic test _____
(attach lab report)

29. Varicella: ❒ 2 vaccines _____ [2] _____
or ❒ proof of disease _____
or ❒ pos. serologic test _____
(attach lab report)

30. PPD **within 1 year mandatory.**
Results to be read within 72 hours
(IF TEST IS POSITIVE, CHEST X-RAY IS REQUIRED). See #31.

_____
(Date Administered)
_____
(Date Read)
POS _____ mm. NEG _____ mm.

31. Chest X-ray Date _____
(NEEDED ONLY IF PPD RESULT IS POSITIVE)
(Please attach a copy of the report) Result _____

32. TD Date _____
or TDAP Date _____

33. Hepatitis B
1st Dose Date _____
2nd Dose Date _____
3rd Dose Date _____

34. Positive Hep B titer Date _____

35. Flu Vaccine Date _____

I verify by my signature that the above named student has met the Technical Standards for successful completion of the Daemen College Athletic Training Education/Nursing/PA or PT programs. My signature verifies that I have reviewed the student's immunization records.

_____ _____
Signature Date

Comments:

Susan Girard
Director of Health & Insurance Services
Daemen College
4380 Main Street
Amherst, New York 14226-3592

(716) 839-8446
FAX (716) 839-8230

HEALTH CARE PROVIDER'S REPORT OF HEALTH EVALUATION

PHYSICAL EXAMINATION

STUDENT'S NAME _____ DATE OF BIRTH _____

1. Height _____ 2. Weight _____ 3. Blood Pressure _____ / _____ 4. Pulse _____

5. Vision Right 20/ _____ corrected to 20/ _____

Left 20/ _____ corrected to 20/ _____

DESCRIBE ANY ABNORMALITIES OF THE FOLLOWING SYSTEMS IN THE SPACE BELOW.

	NORMAL	ABNORMAL
6. Head, Ears, Nose, or Throat		
7. Eyes (Ophthalmoscopic)		
8. Hearing		
9. Neck – Thyroid		
10. Respiratory		
11. Cardiovascular		
12. Gastrointestinal		

	NORMAL	ABNORMAL
13. Skin		
14. Genitourinary (including Hernia)		
15. Musculoskeletal		
16. Metabolic/Endocrine		
17. Neurological		
18. Psychiatric		

	Yes	No
19. To the best of your knowledge, is this person free from physical or mental impairments including alcohol or drug dependency?		
20. To the best of your knowledge, is this person free from communicable diseases that could jeopardize the health of patients or classmates?		
21. Are there any restrictions of physical activity indicated by your examination? Comment below.		
22. Is the patient now under treatment for any medical or emotional condition? Comment below.		
23. Do you have any recommendations regarding the care of this student? Comment below.		
24. Is the person capable of performing the work assigned to him/her in the practice setting as a PA/PT/Nurse or AT student?		
25. How long and in what capacity have you known this student?		

Comments:

Medical Conditions:

Allergies:

Signed _____ , Date _____

Name _____
(PRINT)

Address _____

_____ Zip _____

Tel. No. (Include area code) ( ) _____

Date of Examination _____