New Paltz
STATE UNIVERSITY OF NEW YORK

HEALTH REPORT AND PHYSICIAN'S CERTIFICATE

RETURN TO:
Student Health Service, SUNY New Paltz, 1 Hawk Drive, New Paltz, New York 12561-2443
Fax: (845) 257-3415 ▪ Email: healthservice@newpaltz.edu

Banner Id# N | | | | | | | | |

Student Name: _____ Date of Birth: _____

ATTENTION STUDENT TEACHERS

All 4 pages must be completed and submitted to the Student Health Service by the date indicated on your Student Teaching Clearance email.

(Pages 1 and 2 by you, pages 3 and 4 by your physician)

If you have not received an email from the Student Health Service regarding Student Teaching health clearance requirements, please call our office and ask us to forward you the information as soon as possible.

The completed forms should be mailed, faxed or emailed to the office indicated above. Once the packet is received and reviewed by the Assistant Director, the Student Teaching office will be notified and you will be cleared for student teaching. If there is any information missing from this packet or there is additional information needed, the student will be contacted and alerted.

Any additional questions or concerns, please call our office and speak with our staff.

TO BE COMPLETED BY STUDENTS:

DEMOGRAPHICS:

Student Name: _____

Address: _____
Street City State Zip Code Country

Cell Phone: _____ Other Phone: _____

Parent or Guardian: _____ Relationship: _____

Address: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Primary Health Provider: _____ Years under their care: _____

Address: _____

Phone: _____ Fax: _____

Emergency Contact if Other Than Parent or Guardian:

Person: _____ Relationship: _____

Address: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Insurance Information:

PLEASE INCLUDE A PHOTOCOPY OF FRONT AND BACK OF STUDENT'S HEALTH INSURANCE CARD.

Primary Insurance Company Name: _____

Member ID: _____ Policy Holder's Name: _____

Student Relationship to Insured: ☐ Dependent ☐ Self ☐ Spouse

HEALTH HISTORY:

Are you on the Varsity Athletics Roster? ☐ Yes ☐ No

Diseases in parents and grandparents: eg. Diabetes, Hypertension, Arthritis, Cancer, Heart Disease, Depression, etc:

_____

Diseases in student: check box if history of this condition exists in student:

Infectious Disease	Chronic Medical Disorders	Neurologic/Psychiatric Problems
☐ Chicken Pox	☐ Diabetes	☐ Head Injury/Concussion
☐ Frequent Respiratory Infections	☐ Seizure Disorder	☐ Emotional Disorder
☐ Mononucleosis	☐ Anemia	☐ Depression
☐ Positive TB Skin Test	☐ Sickle Cell Disease	☐ Anxiety
☐ Tuberculosis	☐ Heart Abnormality	☐ Attention Deficit Disorder
☐ Malaria	☐ Kidney Disease	☐ Eating Disorder
☐ HIV/AIDS	☐ Chronic Intestinal/Stomach Problem	☐ Hearing Deficit
☐ Hepatitis A, B, or C	☐ Arthritis	☐ Visual Deficit
☐ Pneumonia	☐ Respiratory Allergies	☐ Speech Deficits
☐ Sexually Transmitted Infection	☐ Hives	☐ Fainting
	☐ Asthma	☐ Alcohol/Drug Addiction
	☐ Cancer	☐ Migraine Headaches
	☐ Orthopedic Problems	☐ Learning Disabilities

Please list any MEDICAL PROBLEMS not noted above. Please clarify any positive responses.

_____

_____

Severe Injuries: ☐ Yes ☐ No Explain: _____

Operations: ☐ Yes ☐ No Explain: _____

CURRENT MEDICATIONS: _____

ALLERGIES: (Please Specify) ☐ No Allergies

Allergies to Medication: _____

Allergies to Food: _____

Allergies to Insects: _____

Student Signature: _____

Student Name: _____ Date of Birth: _____
M/D/Y

TO BE COMPLETED BY STUDENT'S PRIMARY HEALTH PROVIDER:

Provider Name: _____

Address: _____

Phone: _____ **Fax:** _____

STAMP:

Please list any significant past or current medical, surgical, or psychiatric conditions: ☐ None

_____

_____

Please list any ongoing therapy, medications with dosages and directions: ☐ None

_____

_____

ALLERGIES: (Please Specify) ☐ No Allergies Epipen Prescribed? ☐ Yes ☐ No

Allergies to Medication: _____

Allergies to Food: _____

Allergies to Insects: _____

Date of Exam: _____ **Height:** _____ **Weight:** _____ **BMI:** _____ **BP:** _____ **P:** _____

Please list all abnormal findings of your history and physical exam: _____

_____

_____

Please use check off format below to document history and physical:

N = Normal ABN = Abnormal NE = Not Examined

Systems:								**SEX: ☐ Male ☐ Female**			
	N	ABN	NE		N	ABN	NE		N	ABN	NE
Skin				Abdominal Organs				**Female:** Breasts			
HEENT				Ano Rectal Area (If indicated)				Pelvic (If indicated)			
Lungs				Orthopedic: Limbs							
Heart				Spine				**Male:** Testes			
Blood Vessels				Endocrine				Inguinal Canals			
Lymphatics				Neurologic							

Urinalysis:		
	N	ABN
Glucose		
Protein		
Blood		

Information required for Varsity Athletes:

Sickle Cell Trait: ☐ Present ☐ Absent ☐ Unknown

Do you recommend further evaluation? ☐ Yes ☐ No _____

Will you remain involved in this student's care? ☐ Yes ☐ No

Is this student able to participate in all physical activities including intercollegiate athletics? ☐ Yes ☐ No

Is this student able to meet the physical and emotional demands of college? ☐ Yes ☐ No

Provider Signature: _____

New Paltz
STATE UNIVERSITY OF NEW YORK
Student Health Service ▪ Division of Student Affairs
1 Hawk Drive ▪ New Paltz, NY 12561-2443 ▪ 845-257-3400 ▪ Fax 845-257-3415
heathservice@newpaltz.edu

STUDENT TEACHING CLEARANCE TST

To be filled out by student's primary health provider or provide copies of physician documented immunization records.

Banner ID# | N | | | | | | | | |

Office Stamp:

Student Name: _____

Date of Birth: _____

A Tuberculosis Skin Test (TST) completed on or after the date indicated on your Student Teaching Health Clearance email is ***mandatory*** for all Student Teachers. If you have already completed a TST on or after the appropriate date, have your doctor fax us the results. If you did not receive your Student Teaching Clearance email, please call our office and ask us to forward you the information as soon as possible.

PPD (on or after the date indicated on your Student Teaching Clearance email)

☐ PPD test given: Date Given: _____ Date Read: _____ Result: _____
M/D/Y M/D/Y

(Record actual mm of induration, transverse diameter, if no induration, write "0")

☐ Chest x-ray (required if tuberculin skin test is positive) Result: ☐ Normal ☐ Abnormal
PLEASE SUBMIT COPY OF WRITTEN CHEST X-RAY REPORT TO STUDENT HEALTH SERVICE.

Provider Name: _____ Signature: _____