YORK COLLEGE
The City University of New York

OFFICE OF HEALTH SERVICES

Entering York College
□ Spring 20__ □ Fall 20__

□ Day □ Evening □ Transfer

Medical Record

(PERSONAL HISTORY TO BE COMPLETED BY STUDENT)
***Please return original form to:** Health Services Center • AC, Rm. 1F01 •York College Guy R. Brewer Boulevard • Jamaica, NY 11451

Name _____ _____
LAST FIRST MIDDLE MAIDEN

Address _____
NUMBER STREET APT#

_____ _____ _____
CITY STATE ZIP CODE

Telephone Number _____ _____

Date of Birth _____ **EMPL ID #** _____

In case of emergency, notify _____

Home Phone ( ) _____ **Business Phone( )** _____

Gender □ **Male** □ **Female** **Marital Status** □ **Single** □ **Married**

X **Applicant's Signature** _____ **Date** _____

PERSONAL HISTORY (to be completed by student)
Check and describe condition below:

Allergies	□ Yes	□ No	Heart	□ Yes	□ No
Animals	□ Yes	□ No			
Asthma	□ Yes	□ No	Injuries	□ Yes	□ No
Cancer, Cysts, Tumors, etc.	□ Yes	□ No	Kidney	□ Yes	□ No
Convulsions or Epilepsy	□ Yes	□ No	Musculo-Skeletal	□ Yes	□ No
Diabetes	□ Yes	□ No	Nervous	□ Yes	□ No
Drug-Alcohol Habit	□ Yes	□ No	Rheumatic Fever	□ Yes	□ No
Ears	□ Yes	□ No	Thyroid	□ Yes	□ No
Eyes	□ Yes	□ No	Tuberculosis	□ Yes	□ No
Fainting	□ Yes	□ No	Venereal Disease	□ Yes	□ No
Gastro-Intestinal	□ Yes	□ No	Other	□ Yes	□ No

1. **Describe any item checked yes:** _____

_____

2. **List Previous and current serious illness, operations, and current medications:** _____

_____

IMMUNIZATION HISTORY – DATES

TETANUS _____ **HEPATITIS B # 1**

INFLUENZA _____ **HEPATITIS B # 2**

VARICELLA _____ **HEPATITIS B # 3 -**

CONSENT FOR TREATMENT

To be completed by parent or guardian if student is under 18 years, single, and living with his parents.

I authorize for myself or _____, my (son, daughter, ward), examinations, test, and inoculations for the prevention of disease, and treatment in the event of acute illness or injury. Students with chronic illness or serious injury are referred to their private physicians or an appropriated medical facility.

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X _____
Signature □ Student □ Parent or Guardian

Student Name:_____ **Soc Sec#**_____

Physical Examination

(TO BE COMPLETED BY LICENSED PHYSICIAN)

HT. _____in. **WT.**_____lbs. **Vision:** O.D. _____ Corr. _____ O.S. _____ Corr. _____

T.B. Skin Test (within one year of this medical record date) ***or*** ***T.B. Result:*** _____ ***Date*** _____
Chest X-Ray (within three to four years of this medical record date)

B.P. _____/_____mmHg **Pulse** _____/_____min. **Chest X-Ray Result:** _____ Date _____

Hgb _____GM% ***Urine Analysis*:** Protein_____ ***Glucose*** _____

□***TD* (Every 10 years) or** □***TDAP* Date:** _____ **(Please indicate which one)**

All of this MUST be Completed, *Signed* and *Stamped* by M.D.

Normal	Abnormal	Condition	Remarks – Describe Abnormalities Only
□	□	Head and Neck	
□	□	Nose and Sinuses	
□	□	Mouth and Throat	
□	□	Gums and Teeth	
□	□	Eyes	
□	□	Ears, Hearing	
□	□	Chest, Breast, Lungs	
□	□	Heart	
□	□	Vascular	
□	□	Lymphatic System	
□	□	Abdomen and Viscera	
□	□	Hernia	
□	□	Anus and Rectum	
□	□	Genito-Urinary System	
□	□	Endocrine System	
□	□	Spine and Musculoskeletal	
□	□	Skin-Identifying Marks, Scars, Tattoos	
□	□	Neurologic	
□	□	Psychiatric	

Are there any physical disabilities? Describe briefly _____

_____

a. □ Wheelchair Bound **c.** □ Blind or Partially Sighted **e.** □ Neurological Impairments (Polio, Cerebral Palsy, etc.)

b. □ Uses Braces and Crutches **d.** □ Deaf or Hard of Hearing **f.** □ Others – Describe _____

Is there any emotional, mental, or physical condition for which this student is under medical observation and/or taking any medication? □ Yes □ No

Specify: _____

Recommendation for physical activities: □ Full activity □ Limited activity □ No activity Date of examination _____

Physician's Signature _____M.D. Physician's Name (*Print*)_____

Address _____ Phone No. _____

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Doctor's Stamp

THIS FORM MUST BE *SIGNED* AND *STAMPED* BY MEDICAL PROVIDER

⇑ ⇑ ⇑

THIS IS VERY IMPORTANT

Confidentiality Notice

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