



C. W. POST CAMPUS  
720 Northern Boulevard • Brookville, New York 11548 - 1300

**STUDENT TEACHING MEDICAL EVALUATION**

Dear Applicant,

New York State has passed a law requiring students attending colleges and universities in New York State, who were born on or after Jan.1, 1957, to provide proof of immunity against Measles, Mumps and Rubella. Records should indicate two immunizations against Measles and one each against Mumps and Rubella. All immunizations must have been given on or after the first birthday, and all must have been live vaccines--Measles available beginning in 1968 and Mumps available in 1969. Serological proof of immunity or proof of having had the disease (excluding Rubella) is acceptable.

Please obtain a signed immunization history from your physician, or health clinic or record of immunization from your high school or a previous college you may have attended. If you do not have proper immunizations you may get them from the Department of Health.

**IMPORTANT:** You will not be permitted to student teach unless your medical form is properly filed in the Office of Clinical Education and Professional Certifications. Your Physical Examination must have been within a year prior to the student teaching experience. Thank you.

**Please return this completed form to:**  
Dr. Michael P. Hogan, Associate Dean  
Long Island University – CW Post Campus  
Office of Clinical Education and Professional Certifications  
720 Northern Blvd.  
Brookville, N.Y. 11548-1300

STUDENT TEACHER NAME \_\_\_\_\_

SUBJECT AREA \_\_\_\_\_

SOCIAL SECURITY \_\_\_\_\_ SEMESTER \_\_\_\_\_  
(fall/spring & year)

GRAD \_\_\_\_ UNDERGRAD \_\_\_\_

MALE \_\_\_\_ FEMALE \_\_\_\_ BIRTHDATE \_\_\_\_\_

**REPORT OF HEALTH EVALUATION**  
**For Student Teaching Purposes ONLY**

**To the Examining Physician:** Please review the student's history and complete the physician's form. Please complete all appropriate information. This information is strictly for the use of the Office of Clinical Education and Professional Certifications for the purpose of student teaching.

---

Last Name _____	First Name _____	M.I _____
Sex: Male _____	Female _____	Height _____
Weight _____ lbs.	Overweight _____	Underweight _____

\*\*\*\*\*

In your opinion, does this applicant have physical. Mental or emotional conditions that would:

- a) endanger the health or safety of the pupils? \_\_\_\_\_  
Yes/no
- b) cause frequent or prolonged absence from school? \_\_\_\_\_  
Yes/no
- c) have a disturbing influence on children? \_\_\_\_\_  
Yes/no

**Physicians Certification**

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Phone # \_\_\_\_\_  
(Please print)

**M.D. Reg. #:** \_\_\_\_\_

Address \_\_\_\_\_  
(city) (state) (zip)

**Please Affix Office Stamp:**

# C.W.POST CAMPUS/LONG ISLAND UNIVERSITY

## REPORT OF MEDICAL HISTORY

### ALL STUDENTS MUST COMPLETE THIS FORM

Student: Please complete this page before going to your physician for examination.

MIDDLE

SOCIAL SECURITY NO.	DATE OF BIRTH	M/F SEX	E-MAIL
HOME ADDRESS (Number & Street)	CITY OR TOWN	STATE	ZIP CODE HOME TELEPHONE NO.
NAME & ADDRESS OF EMERGENCY CONTACT	RELATIONSHIP	HOME TELEPHONE NO.	BUSINESS TELEPHONE NO.

#### FAMILY HISTORY

	AGE	STATE OF HEALTH	OCCUPATION	AGE OF DEATH	CAUSE OF DEATH
Father					
Mother					
Brother(s)					
Sister(s)					

#### Have any of your relatives had any of the following

	YES	NO	RELATIONSHIP
Tuberculosis			
Diabetes			
Kidney Disease			
Heart Disease			
Arthritis			
Stomach Disease			
<input type="checkbox"/> Asthma <input type="checkbox"/> Hay Fever			
<input type="checkbox"/> Epilepsy <input type="checkbox"/> Convulsions			

#### PERSONAL HISTORY

HAVE YOU HAD:	YES	NO		YES	NO		YES	NO		YES	N O
Scarlet Fever			Insomnia			<b>Chest</b>			Gallbladder Trouble		
Measles			Frequent Anxiety			<input type="checkbox"/> Pain <input type="checkbox"/> Pressure			or Gallstones		
German Measles			Frequent Depression			Chronic Cough			Recurrent Diarrhea		
Mumps			Worry or Nervousness			Palpitations (Heart)			<input type="checkbox"/> Rupture <input type="checkbox"/> Hernia		
Chicken Pox			Recurrent Headaches			High Blood Pressure			Recent Weight:		
Malaria			Recurrent Colds			Low Blood Pressure			<input type="checkbox"/> Gain <input type="checkbox"/> Loss		
<input type="checkbox"/> Gum <input type="checkbox"/> Tooth Trouble			Head Injury with Unconsciousness			Rheumatic Fever			<input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting		
Sinusitis						Heart Murmur			<input type="checkbox"/> Weakness <input type="checkbox"/> Paralysis		
Eye Trouble			<input type="checkbox"/> Hay Fever <input type="checkbox"/> Asthma			Joint Problems:			<input type="checkbox"/> Epilepsy <input type="checkbox"/> Convulsions		
<input type="checkbox"/> Ear <input type="checkbox"/> Nose			Tuberculosis			Trick Knee			URINE: Sugar		
<input type="checkbox"/> Throat Trouble			Shortness of breath			Shoulder			Albumin		
<b>Surgery</b>			<b>Allergy</b>			Back Problems			Frequent Urination		
Appendectomy			Penicillin			<input type="checkbox"/> Tumor <input type="checkbox"/> Cancer <input type="checkbox"/> Cyst			Smoker -how many per day		
Tonsillectomy			Sulfonamides			Jaundice			<b>FEMALES ONLY</b>		
Hernia Repair			Serum			Stomach Trouble			Irregular Periods		
Other			Foods (which)			Intestinal Trouble			Severe Cramps		
			Other			<input type="checkbox"/> Diabetes <input type="checkbox"/> Hypoglycemia			Excessive Flow		

FIRST NAME

	YES	NO
A. Has your physical activity been restricted during the past five years? (Give reasons and duration)		
B. Have you had difficulty with school or teachers? (Give details)		
C. Have you received treatment or counseling for a nervous condition, emotional problems, or substance abuse problems? (Give details)		
D. Have you had any illness or injury or been hospitalized other than already noted? (Give details)		
E. Have you consulted or been treated by clinics, physicians, healers or any other practitioners within the past five years? (Other than routine checkups?)		

#### ADDITIONAL COMMENTS

**RETURN TO:**  
**Dr. Michael P. Hogan**  
**Clinical Ed/Prof Certifications**  
**LIU.C.W. Post Campus**  
**720 Northern Blvd.**  
**Brookville, NY 11548-1300**  
**FAX: (516) 299-2135**

LAST NAME (print)

#### CHECK IF ANY APPLY:

<input type="checkbox"/> Wheelchair Bound	<input type="checkbox"/> Deaf
<input type="checkbox"/> Use of braces or crutches	<input type="checkbox"/> Hearing impaired
<input type="checkbox"/> Blind	<input type="checkbox"/> Other handicap
<input type="checkbox"/> Visually impaired	

Please briefly describe your special needs: \_\_\_\_\_

\_\_\_\_\_  
Student's Signature Date

\_\_\_\_\_  
Physician's Signature Date

# REPORT OF HEALTH EVALUATION

## ALL STUDENTS MUST COMPLETE THIS FORM

**To the Examining Physician:** Please review the student's history and complete the physician's form below. Comment on all positive answers. The information supplied will not affect his/her status; it will be used only as a background for providing health care if necessary. This information is strictly for the use of the Student Health and Counseling Center and will not be released without student consent. Please be sure to sign both sides of form.

M  F

STUDENT'S LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MIDDLE \_\_\_\_\_ SEX \_\_\_\_\_

STUDENT'S SOCIAL SECURITY NUMBER \_\_\_\_\_  RESIDENT \_\_\_\_\_  COMMUTER \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

**MANDATED BY NEW YORK STATE LAW**

The New York State requires all students attending colleges and universities in New York State who were born on or after **JANUARY 1, 1957**, to be immunized against **Measles, Mumps and Rubella**. Records should indicate **TWO** immunizations against **Measles** and **ONE** each against **Mumps and Rubella**. All immunizations must have been live vaccines – measles available in **1968** and mumps available in **1969**. All immunizations must have been given on or after the first birthday.

**IMMUNIZATIONS AND TESTS – Please give complete dates (Month/Day/Year)**

	Dates of immunization			Date of Disease	Titre*
	1st	2nd	3rd		
MMRs	1st	2nd			*(Must attach
Rubeola	1st	2nd			a copy of
Mumps					actual lab
Rubella				Not Acceptable	report)
Menomune/ Menactra					
Polio					
Tetanus Toxoid					
HBV	1st	2nd	3rd		

**I HAVE EXAMINED THE FOLLOWING:**

	FINDINGS:
1. Head, Ears, Nose & Throat	
2. Respiratory	
3. Cardiovascular	
4. Gastrointestinal	
5. Hernia (s)	
6. Eyes	
7. Genitourinary	
8. Musculoskeletal	
9. Metabolic/ Endocrine	
10. Neuropsychiatric	
11. Skin	

**TST I.D. (Mantoux) Mandatory**

Date administered: \_\_\_\_\_  
 Date read: \_\_\_\_\_ Results \_\_\_\_\_ mm  
 PPD Read by: \_\_\_\_\_  
 Physician's Signature \_\_\_\_\_  
 and  
 Office Stamp \_\_\_\_\_  
 (If Mantoux is positive, chest x-ray is required and report must be attached.)  
 Height \_\_\_\_\_ Weight \_\_\_\_\_  
 Blood Pressure \_\_\_\_\_  
 Vision: R \_\_\_\_\_ L \_\_\_\_\_ Corrected: R \_\_\_\_\_ L \_\_\_\_\_  
 Urinalysis: Micro \_\_\_\_\_ Sugar \_\_\_\_\_ Albumin \_\_\_\_\_  
 Hemoglobin (if indicated): \_\_\_\_\_ gms%

Is there loss or seriously impaired function of any paired organ? No  Yes

Recommendations for physical activity? Unlimited  Limited  Explain \_\_\_\_\_

Is the student taking any medication? No  Yes  Please List \_\_\_\_\_

I have examined the above patient and have found him/her physically fit to compete in intercollegiate sports. No  Yes

Have you any general comments? \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

PRINT NAME \_\_\_\_\_

ADDRESS & Office Stamp \_\_\_\_\_

**REQUIRED →**

**RETURN TO:**

**Dr. Michael P. Hogan**  
**Clinical Ed/Prof Certifications**  
**LIU/C.W. Post Campus**  
**720 Northern Blvd.**  
**Brookville, NY 11548-1300**  
**FAX: (516) 299-2135**

**PARENTAL PERMIT**

The law required that parental permission be obtained so that medical attention can be administered to minors. The following consent form should be signed by a parent so that procedures judged necessary may be conducted without undue delays. However, no major operation will be performed, except in extreme emergency, without the parents being contacted and fully informed.

I give my permission for such diagnostic and therapeutic procedures for my son/ daughter and also the release of pertinent information concerning his/her medical condition to other responsible University Officials when deemed necessary.

**Signed**

**Relationship**

Student is covered by : Hospitalization  Medical Care  Surgical Care

If yes, attach a legible copy if insurance card (both sides please).

**STUDENT AFFIDAVIT:** I hereby certify that all the information entered is complete & accurate: Student Signature: \_\_\_\_\_

Date: \_\_\_\_\_