

Please Return to:  
 STATE EDUCATION DEPARTMENT  
 New York State Summer School of the Arts  
 Cultural Education Center  
 222 Madison Ave. Rm. 10D79  
 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"/>	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 (MOTHER/GUARDIAN) (Include Area Code)		12. CELL PHONE (FATHER/GUARDIAN) (Include Area Code)	

### 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)	
18. CELL PHONE (Include Area Code)		19. OTHER PHONE (Include Area Code)	

### Insurance Information

20. INSURANCE CO:		21. INSURED'S NAME (Last, First, Middle Initial)	
22. ADDRESS (Street, City, State, Zip Code)		23. TELEPHONE NUMBER (Include Area Code)	
24. INSURED'S SS #	25. POLICY #	26. 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: **X** \_\_\_\_\_ Date: \_\_\_\_\_

Subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_

Notary Public

Seal

**Please return to:**  
 STATE EDUCATION DEPARTMENT  
 New York State Summer School of the Arts  
 Cultural Education Center  
 222 Madison Ave. Rm. 10D79  
 Albany, NY 12234

# HEALTH ASSESSMENT PART 2.

(To be completed by health care provider)

NAME OF STUDENT (Last, First, Middle Initial) \_\_\_\_\_

27. DATE OF LAST PHYSICAL EXAMINATION \_\_\_\_\_ 28. WEIGHT \_\_\_\_\_ 29. HEIGHT \_\_\_\_\_

30. BLOOD PRESSURE \_\_\_\_\_ 31. VISION \_\_\_\_\_ 32. HEARING \_\_\_\_\_

**33. 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) \_\_\_\_\_

**34. LIST ALL PAST MEDICAL PROBLEMS AND RELATED TREATMENTS:**

None

**35. LIST ALL CURRENT MEDICAL CONDITIONS:**

None

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

MEDICATIONS	DOSAGE	FREQUENCY	CONDITION

**37. PLEASE LIST ANY ALLERGIES**

**38. 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 \_\_\_\_\_