

Please Return to:  
 STATE EDUCATION DEPARTMENT  
 New York State Summer School of the Arts  
 Cultural Education Center  
 222 Madison Ave. Rm. 10D79  
 Albany, NY 12230

# 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		

NYSSSA strives to accommodate all students. For your student's safety, we mandate full prior disclosure of any health issues that the participant has, and reserve the right, in NYSSSA's sole judgment, to discontinue participation of an accepted student for any reason including health.

By signing below, you acknowledge that failure to disclose a known health condition may result in a health risk to your child, and your child being sent home.

### Personal Information

NAME OF STUDENT (Last, First, Middle Initial)			
DATE OF BIRTH	AGE	COUNTY OF RESIDENCE	5. GENDER <input type="checkbox"/> Female <input type="checkbox"/> Male
ADDRESS (Street, City, State, Zip Code)			

### Parent/Guardian Information

NAME OF PARENT/GUARDIAN (Last, (First, Middle Initial)	
8. ADDRESS (Street, City, State, Zip Code)	
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

i. NAME (Last, First, Middle Initial)	RELATIONSHIP
ii. ADDRESS (Street, City, State, Zip Code)	
iii. HOME TELEPHONE NUMBER (Include Area Code)	iv. BUSINESS TELEPHONE NUMBER (Include Area Code)
18. CELL PHONE (Include Area Code)	19. OTHER PHONE (Include Area Code)

### Insurance Information

i. INSURANCE CO:	ii. INSURED'S NAME (Last, First, Middle Initial)
iii. ADDRESS (Street, City, State, Zip Code)	iv. TELEPHONE NUMBER (Include Area Code)
v. INSURED'S SS #	vi. POLICY #
vii. GROUP #	

### THIS PART MUST BE SIGNED AND NOTARIZED

I, \_\_\_\_\_ pursuant to the authority vested in me as parent or guardian of \_\_\_\_\_ do hereby authorize University Health Services, the New York State Summer Institutes, and/or (medical facility to be inserted in blank space at time of treatment) \_\_\_\_\_, upon Consultation with a licensed physician, physician assistant or nurse practitioner, 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 University Health Services. I warrant that my child's health is fully described in the Health Assessment Part 2, including all past and current known medical and/or psychiatric conditions and that my child has no medical and/or psychiatric condition that with or without reasonable accommodation, would prevent he/she from participating in the New York State Summer School of the Arts. I agree to hold harmless the New York State Summer School of the Arts of the State of New York, its officers, employees and agents from any and all liability, claims or causes of action arising out of my child's participation in activities associated with the program.

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 (NYSSSA)  
 Cultural Education Center  
 222 Madison Ave. Rm. 10D79  
 Albany, NY 12230

# HEALTH ASSESSMENT PART 2.

To be completed by the Health Care Provider **in consultation with the patient's Mental Health Provider where appropriate.**  
 Parents are mandated to provide a full prior disclosure of any health issues of the student patient.

NAME OF STUDENT (Last, First, Middle Initial)

NYSSSA PROGRAM STUDENT WILL ATTEND:		WEIGHT	HEIGHT
BLOOD PRESSURE	DATE OF LAST PHYSICAL EXAMINATION		ALLERGIES

MEDICAL HISTORY (check all that apply)

<input type="checkbox"/> Asthma	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression
<input type="checkbox"/> Suicidal Behavior/Thoughts	<input type="checkbox"/> Eczema	<input type="checkbox"/> Injuries	<input type="checkbox"/> Vision/hearing disorder	<input type="checkbox"/> Seasonal allergy
<input type="checkbox"/> Chronic intestinal problems	<input type="checkbox"/> Emotional instability	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Surgeries	<input type="checkbox"/> Sleep disorder
<input type="checkbox"/> Stomach Conditions	<input type="checkbox"/> History of Cutting	<input type="checkbox"/> Alcohol/Drug Abuse	<input type="checkbox"/> Orthopedic problems	<input type="checkbox"/> Tuberculosis or TB Contact
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Lung problems	<input type="checkbox"/> History of Seizures	<input type="checkbox"/> Bowel or Bladder Disease
<input type="checkbox"/> Other (please specify):				

LIST ALL CURRENT AND PAST **PHYSICAL MEDICAL** CONDITIONS AND RELATED TREATMENTS (use additional space as needed):

None

LIST ALL CURRENT AND PAST **PSYCHIATRIC/MENTAL HEALTH** CONDITIONS AND RELATED TREATMENTS (use additional space as needed):

None

LIST ALL MEDICATIONS CURRENTLY BEING TAKEN (INCLUDING OVER THE COUNTER) WITH DOSAGE, FREQUENCY AND CONDITION FOR WHICH IT IS BEING TAKEN: **Please note-Residential Life Staff hold ALL medications. Students will be expected to obtain medication(s) from residential life staff at ordered times or as needed and self-administer their own medication(s). Exceptions: Epinephrine via auto-injector, and Emergency Glucagon for students diagnosed with diabetes.**

MEDICATIONS	DOSAGE	FREQUENCY	CONDITION

PLEASE LIST ANY DRUG/FOOD ALLERGIES

**Immunizations (Fill in dates mm/dd/yyyy)**

- DIPHTHERIA, PERTUSSIS, AND TETANUS TOXOIDS (dates) \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_,
- Tdap (age 11 and older) \_\_\_\_\_
- ORAL POLIOMYELITIS VACCINE **OR**  INACTIVATED POLIO VACCINE (Dates) \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_
- MMR immunization (date) \_\_\_\_\_, \_\_\_\_\_
  
- VARICELLA (Date Chicken Pox was diagnosed): \_\_\_\_\_ **OR** Date of VARICELLA VACCINE \_\_\_\_\_
- HEPATITIS B VACCINE (date) \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

**MENINGOCOCCAL MENINGITIS IMMUNIZATION**

- 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) \_\_\_\_\_
  
- OTHER IMMUNIZATIONS: (specify type & Date) \_\_\_\_\_

**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.
- c. **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.
- d. 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
- e. 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 \_\_\_\_\_ which is within the past year.  
(DATE)

All medical/psychiatric conditions and therapies are noted above or on attached pages. Please initial if additional pages attached. \_\_\_\_\_. Where applicable, the patient's mental health practitioner has been consulted. Please note under exceptions if it is your recommendation that a separate Health Form be completed by the patient's Mental Health Practitioner.

It is in my opinion that the above named patient may participate in the New York State Summer School of the Arts without restrictions.

Exceptions (if any): \_\_\_\_\_

Date \_\_\_\_\_

Health Care Provider Address

\_\_\_\_\_  
\_\_\_\_\_

Telephone number \_\_\_\_\_ FAX number \_\_\_\_\_

E-mail Address \_\_\_\_\_

Signature of Health Care Provider \_\_\_\_\_

Print Name \_\_\_\_\_

**New York State Summer School of the Arts**

**Please return to:**  
 STATE EDUCATION DEPARTMENT  
 New York State Summer School of the Arts  
 Cultural Education Center  
 222 Madison Ave. Rm. 10D79  
 Albany, NY 12230

**HEALTH ASSESSMENT  
 PART 3.**

**Over the Counter Medication Order**

To be completed by the Health Care Provider. **Students will not be administered over the counter medications** (including vitamins and supplements) without this order on file with the NYSSSA Program.

**Parents must provide any medications to be taken by the student ALL medications are held by NYSSSA staff.**

**Please attach any additional Over the Counter Medication Orders to this document.**

Student's Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Medication	Indications for use and conditions under which medication should be administered Please add indications if needed	Dosage and Route of Administration	Frequency and/or Time of Administration	Additional Information	Health Care Provider Consent (Please Initial)	Parent Consent (Please Initial)
Acetaminophen Elixir (160mg/5ml)	Pain or Fever > 101° F	_____ mg po	Q 4-6 H PRN			
Acetaminophen Regular Strength (325mg Tablets)	Pain or Fever > 101° F	_____ mg po	Q 4-6 H PRN			
Bacitracin/Neosporin/ Antibiotic Ointment						
Anti-itch Gel/Spray (Camphor 0.45%)		1 Topical application to site	Q 6 H PRN			
Benadryl Ointment		1 Topical application to site	Q 6H PRN			
Diphenhydramine Benadryl (12.5mg/5ml)		_____ mg po	Q 6 H PRN			
Diphenhydramine Benadryl 25mg Capsules		_____ mg po	Q 6 H PRN			
Colace/Dulcolax						
Ibuprofen (100mg/5ml)	Pain or Fever > 101° F	_____ mg po	Q 6-8 H PRN			
Ibuprofen (200 mg Tablets)	Pain or Fever > 101° F	_____ mg po	Q 6-8 H PRN			
Vitamin Supplements (Multit, Vit. D etc)						
Pepto bismol/ antacid						

**To be completed by Healthcare Provider:**

I authorize the medications initialed above to be provided to this student as ordered, for this student to self-administer.

Name/Title of Licensed Health Provider (Please Print) \_\_\_\_\_

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

Provider's Signature: \_\_\_\_\_ Initials: \_\_\_\_\_

Phone: \_\_\_\_\_

**To be completed by Parent:**

I authorize the above medications to be provided to my child as ordered by my healthcare provider, for my child to self-administer.

Parent/Guardian (Please Print) \_\_\_\_\_

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

Parent/Guardian Signature: \_\_\_\_\_ Initials \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell: \_\_\_\_\_