

**OFFICE OF HEALTH SERVICES**

# 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

Entering York College

Spring 20\_\_

Fall 20\_\_

Day

Evening

Transfer

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( ) \_\_\_\_\_

Marital Status  Single  Married

X

Applicant's Signature \_\_\_\_\_

Date \_\_\_\_\_

**PERSONAL HISTORY (to be completed by student)**

Check and describe condition below:

Allergies  Yes  No  
 Animals  Yes  No  
 Asthma  Yes  No  
 Cancer, Cysts, Tumors, etc.  Yes  No  
 Convulsions or Epilepsy  Yes  No  
 Diabetes  Yes  No  
 Drug-Alcohol Habit  Yes  No

Heart  Yes  No  
 Injuries  Yes  No  
 Kidney  Yes  No  
 Musculo-Skeletal  Yes  No  
 Nervous  Yes  No  
 Rheumatic Fever  Yes  No

Ears  Yes  No  
 Eyes  Yes  No  
 Fainting  Yes  No  
 Gastro-Intestinal  Yes  No

Thyroid  Yes  No  
 Tuberculosis  Yes  No  
 Venereal Disease  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.

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
<input type="checkbox"/>	<input type="checkbox"/>	Head and Neck	
<input type="checkbox"/>	<input type="checkbox"/>	Nose and Sinuses	
<input type="checkbox"/>	<input type="checkbox"/>	Mouth and Throat	
<input type="checkbox"/>	<input type="checkbox"/>	Gums and Teeth	
<input type="checkbox"/>	<input type="checkbox"/>	Eyes	
<input type="checkbox"/>	<input type="checkbox"/>	Ears, Hearing	
<input type="checkbox"/>	<input type="checkbox"/>	Chest, Breast, Lungs	
<input type="checkbox"/>	<input type="checkbox"/>	Heart	
<input type="checkbox"/>	<input type="checkbox"/>	Vascular	
<input type="checkbox"/>	<input type="checkbox"/>	Lymphatic System	
<input type="checkbox"/>	<input type="checkbox"/>	Abdomen and Viscera	
<input type="checkbox"/>	<input type="checkbox"/>	Hernia	
<input type="checkbox"/>	<input type="checkbox"/>	Anus and Rectum	
<input type="checkbox"/>	<input type="checkbox"/>	Genito-Urinary System	
<input type="checkbox"/>	<input type="checkbox"/>	Endocrine System	
<input type="checkbox"/>	<input type="checkbox"/>	Spine and Musculoskeletal	
<input type="checkbox"/>	<input type="checkbox"/>	Skin-Identifying Marks, Scars, Tattoos	
<input type="checkbox"/>	<input type="checkbox"/>	Neurologic	
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric	

Are there any physical disabilities? Describe briefly \_\_\_\_\_

- a.  Wheelchair Bound
- b.  Uses Braces and Crutches
- c.  Blind or Partially Sighted
- d.  Deaf or Hard of Hearing
- e.  Neurological Impairments (Polio, Cerebral Palsy, etc.)
- 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: \_\_\_\_\_

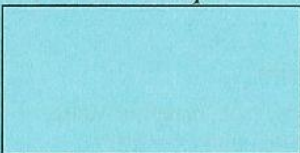
Recommendation for physical activities:  Full activity  Limited activity  No activity Date of examination \_\_\_\_\_

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**

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