

#### Office of the Associate Dean Clinical Education and Professional Certifications liu.edu

COLLEGE OF EDUCATION, INFORMATION AND TECHNOLOGY 720 Northern Boulevard Brookville, New York 11548 - 1300

516.299.2870 516.299.2135 Fax

#### 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.

<u>IMPORTANT:</u> You <u>will not</u> 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 LIU Post 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
GRADUNDERGRAD	
MALEFEMALE	BIRTHDATE

## LIU POST Office of Clinical Education and Professional Certifications

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

<u>To the Examining Physician:</u> 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 Na	ime	M.I
Sex: Male	Female	Heigh	t
Weightlbs.	Overweight	Under	weight
	******	*******	****
• -	nis applicant have physic e health or safety of the		ional conditions that would
		Yes/no	O
b) cause freque	ent of prolonged absence		Yes/no
c) have a distur	rbing influence on child		
0, 110,000		Yes/no	·
Physicians Certifica			
Doctor's Signature			_ Date
Doctor's Name		Pł	none #
M.D. Reg. #:	(Please print)		
ин. <b>р. к</b> ед. п			
Address			
	(city)	(state)	(zip)

**Please Affix Office Stamp:** 

### LIU POST REPORT OF MEDICAL HISTORY

ALL STUDENTS MUST COMPLETE THIS FORM Student: Please complete this page before going to your physician for examination.

SOCIAL SECURITY NO. DATE OF					DATE OF I	BIRTH SEX						E-MAIL				
HOME ADDRESS (Number & Street) CITY OR TOWN			OWN	STATE ZIP CODE				HOME TELEPHONE NO.								
NAME &AD	DRESS OF	EMERG	ENCY (	CONTACT		RELAT	IONSHIP	HOM	ME TELEPHON	NE NO.		BUSIN	ESS TEL	EPHONE	NO.	
FAMILY HISTORY STATE OF AGE OF		AGE OF	CAU	JSE OF	Have any of your relatives had			any of the	ATIONSH	IID.						
Father	AGE	HEAI	LTH	OCCUPATION	DEATH	DE	EATH	-	Tuberculosis			TES	NO	KEL	THOMSII	
Mother								1	Diabetes							
Would									Kidney Diseas	se						_
Brother(s)								-	Heart Disease							
Diother(s)								1	Arthritis							
								-	Stomach Dise	956						
Sister(s)								-	Stomach Disease  ☐ Asthma ☐ Hay Fever		r					
Sister(s)								-								
			l			I		l	☐Epilepsy ☐	_ Convuisio	ons		l			
PERSONAL	HISTORY															
HAVE YOU H	AD:	YES	NO	1		YES	NO	I		YES	NO				YES	NO
Scarlet Fever	AD.	1 Lij	110	Insomnia		ILS	NO	Chest		ILS	110	Gallbladder Trouble			TLS	110
Measles				Frequent Anxiety				Pain Pressu	ıre				Gallstones			
German Measle Mumps	S			Frequent Depressi Worry or Nervous				Chronic Cough Palpitations (Hear	4)			Recurrent Diarrhea  Rupture Hernia				
Chicken Pox				Recurrent Headac				High Blood Pressure		Recent Wei						
Malaria				Recurrent Colds				Low Blood Pressure				Gain Loss				
☐Gum ☐Toot	h Trouble			Head Injury with				Rheumatic Fever				Dizzine				
Sinusitis Eye Trouble				Unconsciousness  Hay Fever	Acthmo			Heart Murmur Joint Problems:				☐ Weakness ☐ Paralysis				
Eye Houble  Ear Nose	;		1	Tuberculosis	_Asuillia			Trick Knee				☐ Epilepsy ☐ Convulsion URINE: Sugar				
☐ Throat Troul				Shortness of breat	h			Shoulder				Albumin				
Surgery				Allergy				Back Problems				Frequent Urination				
Appendectom Tonsillectomy				Penicillin Sulfonamides				☐ Tumor☐ Cand	cer LCyst			Smoker –how many per day FEMALES ONLY				
Hernia Repair				Serum				Stomach Trouble				Irregular Periods				
Other				Foods (which)				Intestinal Trouble				Severe Crai				
				Other				☐Diabetes ☐Hy	poglycemia			Excessive F	Flow			
						YES	NO	ADDITIONAL	COMMENTS							
A. Has your p	hysical acti	vity been	restrict	ed during the past five	e years?	TLO	110	I DDITTO: WIE	COMMENTS							
(Give reas	sons and dui	ation)			,					RF	ETU	RN TO	) <u>:</u>			
B. Have you		ty with s	chool or	teachers?										2		
(Give details)  C. Have you received treatment or counseling for a nervous condition,		dition			Dr. Michael P. Hogan Clinical Ed/Prof Certifications											
•				e problems?	idition,					Cli	ınıca	I Ed/Pro	of Cert	111cat10	ons	
(Give deta				•									W. Post			
D. Have you had any illness or injury or been hospitalized other than already noted? (Give details)		than			720 Northern Blvd. Brookville, NY 11548-1300											
			eated by	clinics, physicians, he	ealers or								116, 141 516) 299.		300	
any other j	practitioners in routine ch	within t	he past f									212121 (6	-10) =>>			
CHECK IF A	NY APPLY Wheelcha		i		Deaf	;										
	Use of bra Blind	aces or cr			Hear	ring impa er handica			Student's Signa	ature						Date
Please briefly	_ Visually i		al needs:				_		Physician's Sig	gnature						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. STUDENT'S LAST NAME FIRST NAME RESIDENT COMMUTER STUDENT'S SOCIAL SECURITY NUMBER 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) **Date of Disease** Titre\* Dates of immunization 1st \*(Must attach 2nd Rubeola a copy of Mumps actual lab Not Acceptable report) Rubella Menomune/ Menactra Polio Tetanus Toxoid HBV 3rd TST I.D. (Mantoux) Mandatory I HAVE EXAMINED THE FOLLOWING: Date administered:\_\_\_\_ FINDINGS: Date read: mm PPD Read by:\_\_\_\_\_ 1. Head, Ears, Nose & Throat Physician's Signature 2. Respiratory and 3. Cardiovascular Office Stamp 4. Gastrointestinal (If Mantoux is positive, chest x-ray is required and report must be attached.) 5. Hernia (s) Height\_\_\_\_ \_\_\_\_\_Weight\_\_\_ 6. Eyes Blood Pressure\_ 7. Genitourinary Vision: R\_\_\_\_\_L\_\_\_ Corrected: R\_ 8. Musculoskeletal Urinalysis: Micro\_\_\_\_\_Sugar\_\_\_\_Albumin\_\_\_\_ 9. Metabolic/ Endocrine Hemoglobin (if indicated): 10. Neuropsychiatric 11. Skin Yes Is there loss or seriously impaired function of any paired organ? No 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 RETURN TO: Have you any general comments? \_\_\_ Dr. Michael P. Hogan Physician's Signature \_\_\_\_\_ Clinical Ed/Prof Certifications PRINT NAME ADDRESS & Office Stamp LIU/C.W. Post Campus REQUIRED  $\rightarrow$ \_ 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. **Relationship** Surgical Care Student is covered by: Hospitalization Medical 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:

Date:

Student Signature: