

Health Assessment Form

To the examining provider: please complete this form with comments on all positive answers. (Use back of sheet as needed.) Since this student has already been accepted for admission, the information supplied will not affect his/her status and will be used only as background for providing any needed care by the health services. It will not be released to anyone without the student's consent.

Name _____ DOB: _____ Gender: F M trans
Last First

Vitals: HT _____ WT _____ BMI _____

BP _____/_____ HR _____ RR _____

Pap smear date (if completed): _____

Result _____

ROS and physical exam:

1. Head, ears, nose, or throat _____
2. Eyes: Correction? Contacts/type _____
3. Cardiovascular _____
4. Respiratory _____
5. Gastrointestinal _____
6. Genitourinary _____
7. Musculoskeletal _____
8. Metabolic or endocrine _____
9. Neuropsychiatric _____
10. Skin _____

Is student currently taking any medication? no yes _____

Does student have any known allergies to medications, food, environment? no yes _____

Recommendations for physical activity (PE): unlimited limited (explain) _____

Is the student now under treatment for any medical condition? no yes Diagnosis: _____

History of, or current concern/treatment for eating disorder? _____

Do you have any recommendations regarding the care of this student? no yes If yes, what? _____

Is the student now under treatment for any emotional condition? no yes Diagnosis: _____

Is the student under treatment for any attention disorder or learning disorder conditions? no yes

If so, what?/medications/accommodations: _____

How long have you known this student? _____

Please send relevant medical records to us to help us coordinate and continue care. Thank you.

HEALTH PROVIDER'S SIGNATURE

PLEASE PRINT LAST NAME

DATE

ADDRESS

PHONE

FAX