LIU Post
Medical Services
720 Northern Boulevard • Brookville, NY 11548-1300
516-299-2345 • FAX: 516-299-4113

HEALTH EVALUATION

Last Name: _____ First Name: _____ Middle Initial:_____

LIU ID/SS #: _____ Date of Birth: _____/_____/_____ Age: _____
mm dd yyyy

HEALTH CARE PROVIDER'S EXAMINATION (to be completed by M.D., D.O., N.P., P.A. only)

Drug Allergies: _____ Food Allergies or Intolerance:_____

Medications (Please include prescription medications and any over-the-counter medications taken daily):

_____

Height:_____ Weight:_____ Blood Pressure:_____ Heart Rate:_____

Vision R:_____ L:_____ Corrected R:_____ L:_____ Hearing Impaired? ❑ YES ❑ NO

System	Satisfactory	Unsatisfactory	Comments
HEENT			
Respiratory			
Cardiovascular			
Abdominal			
Genitourinary			
Musculoskeletal			
Skin			
Neurovascular			

Routine Urinalysis: Micro:_____ Sugar:_____ Albumin:_____ Hemoglobin (If indicated): _____gms

Most Recent Tetanus: Immunization Date			
Hepatitis B: Immunization Date(s)	1st	2nd	3rd

TST I.D. – Mandatory:
Date and site placed____/____/____ RFA or LFA (circle one) Wheal: _____mm Date read ____/____/____ Results _____mm
mm dd yyyy mm dd yyyy

If the TST is positive, a QFT blood test must be done. If the QFT is positive, a chest x-ray must be done and all reports must be attached to this form. If student was treated, please also attach treatment history.

Student is cleared for all physical education and/or athletic activities ❑ YES ❑ NO

If no, please explain why: _____

Are there any emotional problems the University should be aware of in order to assist the student in achieving their educational goals?

❑ YES ❑ NO If yes, please explain _____

Health care Provider's Name (Print):_____ Date of Exam:_____

*Signature: _____

License #:_____ Phone:_____

*This form will not be accepted without health care provider's signature and stamp.

*Stamp: