Center For Pre-College Programs Medical Form – Consortium Pre-College

SECTION I - TO BE COMPLETED BY PARENT(S)/GUARDIAN			
Child's Name		*Gender* ☐ *Male* ☐ *Female*	*Date of Birth* / /
Does Child Have Health Insurance? ☐ *Yes* ☐ *No*	*If Yes, Name of Child's Health Insurance Carrier*		
Parent/Guardian Name	*Home Telephone Number*	*Work Telephone Number*	*Cell Phone Number*
Parent/Guardian Name	*Home Telephone Number*	*Work Telephone Number*	*Cell Phone Number*
Emergency Contact (other than above)	*Home Telephone Number*	*Work Telephone Number*	*Cell Phone Number*
I give consent for a health care provider, the child's care provider and/or the child's sending school officials and health professionals to release to NJIT the minimum necessary of the child's personal health information ("PHI") in a medical emergency during an NJIT program.			
Signature/Date		*This form may be released to WIC.* ☐ *Yes* ☐ *No*	

PERSONAL HEALTH ASSESSMENT: For the following questions, please check yes if you are presently having a problem or have had a problem in the past. If there is no significant problem, check no. Briefly explain all the answers.
TO BE COMPLETED BY PARENT(S)/GUARDIAN:

Cardiovascular:	Yes	No	Past Illness:	Yes	No	Mental Health:	Yes	No
Heart Murmur/palpitations	☐	☐	Malaria, Hepatitis, Mononucleosis, Chicken pox and other childhood diseases	☐	☐	Any problem with your emotional health, requiring any form of therapy, including medication	☐	☐
Chest pain	☐	☐	Loss or absence of any body parts	☐	☐	Have you ever experienced a serious dietary problem (anorexia, bulimia, obesity)	☐	☐
Rheumatic fever	☐	☐	Severe/Frequent colds or flu	☐	☐			
High Blood pressure	☐	☐						
Irregular heartbeat	☐	☐	Hospitalization:	☐	☐	Medications:	☐	☐
Blood clots (not menstrual clots)	☐	☐	Have you ever been admitted to a hospital?	☐	☐	(Vitamins, over-the-counter-medications and prescriptions):	☐	☐
Enlarged heart	☐	☐	Have you ever had surgery?	☐	☐	Amount:_____		
Respiratory:	☐	☐	Eye-Ear-Nose-Throat (EENT):	☐	☐	Neurology:	☐	☐
Asthma	☐	☐	Any problems with your eyes, ears, nose or throat	☐	☐	Seizure or convulsions	☐	☐
Chest infection	☐	☐	Hearing impairment	☐	☐	Fainting or blackouts	☐	☐
Shortness of breath	☐	☐	Loss of eye or eyesight	☐	☐	Dizziness	☐	☐
Wheezing	☐	☐						
Skin:	☐	☐	Blood:	☐	☐	Gastrointestinal:	☐	☐
Any problems with your skin?	☐	☐	Anemia	☐	☐	Problems with any part of your intestinal tract or stomach?	☐	☐
Skin rashes	☐	☐	Sickle-cell disease	☐	☐	Jaundice	☐	☐
			Abnormal bleeding or bruising	☐	☐	Hernia	☐	☐
Endocrine:	☐	☐	Bone and Joint:	☐	☐	Allergy:	☐	☐
Thyroid disease	☐	☐	Any serious disability deformity or disease of bone, joint, or muscle?	☐	☐	Any significant allergy to food, medications, insects, pollen?	☐	☐
Diabetes	☐	☐				Food?		
						Other?		
Urinary:	☐	☐	Kidney Stones:	☐	☐			
Impaired function of any part of your urinary tract or loss of a kidney	☐	☐						

I certify that the statements in Sections I & II are true to the best of my knowledge. I agree and acknowledge that a failure to disclose any material information about, and current or past problem or condition of, my child may result in the immediate exclusion of my child from the NJIT program in NJIT's sole discretion. I authorize NJIT to arrange for treatment of my child in the event of medical emergency, serious illness or injury, including care at a medical facility. In case of medical emergency, I understand that NJIT will attempt to notify me as soon as possible. Failure to contact me following reasonable efforts to do so shall not prevent NJIT from authorizing and/or arranging for emergency treatment as necessary. I agree to provide health insurance for my child at all times during the NJIT program and to hold NJIT, its trustees, officers, employees and agents (collectively, "NJIT") harmless from any and all claims, liabilities and/or costs associated with providing medical care or treatment. I hereby release NJIT from any and all claims, and covenant not to sue NJIT, for injuries, damages and/or other costs incurred by my child, by me and/or by any third party as a result of NJIT authorizing, and/or arranging for, medical treatment / care for my child.

Parent/Guardian Signature: _____ Date _____/_____/_____

Please see reverse side for Section II (Please have completed by doctor)

SECTION II – TO BE COMPLETED BY HEALTHCARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? □Yes □No

Abnormalities Noted:		
	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☐ Immunization Record Attached (*The child's immunizations must be up-to-date. The Immunization Record must be legible.*) ☐ Date Next Immunization Due:

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐Capillary ☐Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

I have examined the above student and reviewed his/her health history. It is my opinion that the student is medically cleared to participate fully in all Center for Pre-College Programs sponsored activities, unless noted above.

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	