LONG ISLAND UNIVERSITY

HEALTH EVALUATION FORM

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

LIU ID #_____ **Date of Birth:**_____/_____/_____ **Age:** ____
Month Day Year

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 both prescription and over-the counter meds taken daily): _____
_____

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

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

Vision Exam: R:___/20 L ___/20 Comments _____

Most Recent Tetanus: Immunization Date _____

TST I.D. – Recommended

Date and site placed____/____/____RFA or LFA (circle one)
Wheal:_____mm Date read____/____/____Results_____mm

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.

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

If no, please explain why: _____

Health care Provider's Name (Print):_____

*****Signature:**_____ **Date of Exam:**_____/_____/_____
Month Day Year

License #:_____

Phone: _____

*****Document will not be accepted if not signed and stamped**

***** Healthcare Providers Stamp**

Please upload this document to your Sportware account and email to:
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