# BARUCH LEADERSHIP ACADEMY

Health & Medical Form (This page to be completed by parent before presentation to physician.)

Student's Last Name: First Name:

Age: Birth Date: Sex: Male Female

Parent or Guardian Information:

Mother's Name: Father's Name:

Work Phone: Work Phone:

Mobile Phone: Mobile Phone:

Emergency Contact (if a parent is not available in the case of an emergency, the Academy will attempt to contact the following person):

Name: Relation: Best Phone:

Important: Has this student been exposed to any communicable disease during the three weeks prior to Leadership Academy attendance? No Yes, if yes, please state type of exposure:

Health History (please check all that apply and provide approximate dates):

- Ear Infections........................................
- Rheumatic Fever........................................
- Behavior........................................
- Ivy Poisoning........................................
- Other Drugs........................................
- German Measles........................................
- Allergies........................................
- Convulsion........................................
- Asthma........................................
- Insect Stings........................................
- Chicken Pox........................................
- Mumps........................................
- Diseases........................................
- Diabetes........................................
- Hay Fever........................................
- Penicillin........................................
- Measles........................................

Other Contagious Illnesses

Other Past Illnesses

Operations or Serious Injuries (include dates)

Chronic or Recurring Illness

Medication taken

Any specific activities to be encouraged?

Any conditions that require activity to be restricted?

Permissions for all activities unless otherwise noted by doctor

Consent for Emergency Medical Treatment

I do hereby give authority to the Baruch College Leadership Academy staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.

Name Relationship Phone

Signature Date

Mail or email your completed Parent Agreement, Health & Medical Forms and payment to:
Baruch College, Attn: Leadership Academy, 55 Lexington Ave, Box H-720, New York, NY 10010
Email: academy@baruch.cuny.edu

# BARUCH LEADERSHIP ACADEMY

Health & Medical Form (This page to be completed by physician.)

The purpose of this health record is to provide the staff with pertinent information which will help to serve the needs of this child while attending the Baruch College Leadership Academy.

Immunization History- This is a record of dates of basic immunization and most recent booster doses.

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|---|---|---|---|---|---|
| DPaP, DTP or TD | Date | Date | Date | Date | Date |
| Polio | Date | Date | Date | Date | Date |
| MMR | Date | Date | Date | Date | Date |
| Hemophilus Influenzae type b | Date | Date | Date | Date | Date |
| Hepatitis B | Date | Date | Date | Date | Date |
| Varicella | Date | Date | Date | Date | Date |
| Other | | Date | Date | | |

Medical Examination- To be filled out by a licensed physician. Examination is acceptable when performed no more than 6 months prior to arrival at camp.

Code: S = Satisfactory; X = Not Satisfactory (Explain); 0 = Not Examined

General Appearance

Height ______ Weight ______ Blood Pressure ______ Hgb. Test (date) ______ Urinalysis (date) ______

Eyes ______ Vision ______ w/Glasses ______ Posture & Spine ______ Throat - Tonsils ______

Heart ______ Ears ______ Hearing ______ Extremeties ______ Feet ______

Lungs ______ Skin ______ Nose ______ Teeth ______ Hernia ______

Abdomen ______ Genitalia ______

Neurological Findings ______

Describe Abnormal Finding and/or Handicapping Conditions ______

Has child ever received products containing horse serum? ______

Allergy: (Please specify) ______

Recommendations and restrictions while in Academy. ______

Special Diet ______ Special Medicine (name it) ______

Is parent/guardian sending special medicine? ______

Swimming ______ Activity Restriction ______

General Appraisal: ______

I have examined the person herein described, reviewed his/her health history and it is my opinion that he/she is physically able to engage in Baruch Leadership Academy. PLEASE AFFIX OFFICE STAMP.

Examining Physician (Signature) ______ Date of Examination ______

Physician's Name (Please Print) ______ Telephone ______

Address ______