There are a number of steps involved in completing the health evaluation packet. This process may take several weeks to complete. The deadline to upload submissions is June 15th for Fall entrants, January 1st for Spring entrants, or June 1st for Summer students. Please take the time to carefully read the instructions on this page. This will give you an opportunity to plan the actions you must take to complete the packet, submit it by the deadline, and avoid penalties and registration delays.

The Office of Health and Counseling requires all students to upload a copy of a fully completed and signed Health Evaluation Packet. The Health Evaluation Packet includes the following forms:

1. Immunization Records
2. Tuberculosis Screening
3. Physical Examination

To upload your completed health evaluation:

1. Go to https://eforms.pratt.edu/lincdoc/doc/run/pratt/HEALTH_DOCS_UPLOADS (A link can also be found at www.pratt.edu/healthevaluation)
2. Upload each of the three forms of the health evaluation packet individually. You will have the opportunity to attach supporting documentation. (ex: vaccine records or testing reports) Make sure the form you are uploading matches the type of document selected. Mismatched or incomplete forms will be rejected and will result in a delay in the approval process.
3. For each successful upload, you will receive a confirmation email to your Pratt webmail account.
4. Once the Office of Health and Counseling has fully reviewed and accepted your Health Evaluation Packet, an email will be sent to your Pratt webmail account notifying you that the process has been successfully completed.

Please keep in mind the following tips to ensure your forms are completed accurately:

• Gather your immunization/vaccination records. All records must be written or translated into English. These records may be located through your previous school/college, your doctor’s office, or your parents. Be aware it may take some time to contact previous schools or complete request forms.

• Schedule an appointment with your personal physician for a full health evaluation and for your provider to complete the health evaluation packet. You may also schedule an appointment with an urgent care center or clinic if your medical provider is not available.

• Make sure your physical exam is completed no more than 6 months prior to your entry at Pratt. For example, if you are entering Pratt in September, the physical exam should be completed after March. Physical exams completed earlier will not be accepted.

• Have your medical provider complete a tuberculosis screening. All students are required to submit tuberculosis testing completed within the last 12 months.

• Provide the name and phone number of an emergency contact. For students entering Pratt under the age of 18, please also ensure the Emergency Medical Authorization is completed by a parent or guardian.

• Finally, check that each form has been completed in full and your medical provider has signed or stamped every form in the designated box.
# Immunization Record 2019–2020

**Pratt Institute Office of Health and Counseling**  
200 Willoughby Avenue, Willoughby Hall  
Brooklyn, NY 11205  
Phone: 718-399-4542  
Fax: 718-399-4544  
health@pratt.edu

**Name:**  
Last  
First  
MI  

**Date of Birth:**  
Month  /  Day  /  Year  
Pratt ID #:  

**Emergency Contact:**  
Name  
Relation  
Phone Number

---

**Emergency Medical Authorization (For parents/guardian of students under the age of 18)**  
I, the undersigned parent or legal guardian of ____________________________, do hereby authorize Pratt Institute, on my behalf, to consent to any emergency hospital care or treatment to be rendered him or her upon the advice of any licensed provider. I agree to be responsible for all necessary charges incurred by any hospitalization or treatment rendered pursuant to this authorization.

**Parent/Guardian Signature**  
Relationship  
Date

---

## Required Vaccines

**MMR (Measles, Mumps, Rubella)**  
**REQUIRED**

<table>
<thead>
<tr>
<th>Vaccination</th>
<th>Vaccine Date(s) (Month/Day/Year)</th>
<th>Or Attach Serology Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 MMRs (measles, mumps, &amp; rubella vaccine) 1st dose after 1st birthday; 2nd dose at least 28 days later. OR Individual vaccines below</td>
<td>#1</td>
<td>Must attach lab results</td>
</tr>
<tr>
<td>2 Measles 1st dose after 1st birthday; 2nd dose at least 28 days after</td>
<td>#1</td>
<td>Must attach lab results</td>
</tr>
<tr>
<td>1 Mumps After 1st birthday</td>
<td>#2</td>
<td>Must attach lab results</td>
</tr>
<tr>
<td>1 Rubella After 1st birthday</td>
<td>#1</td>
<td>Must attach lab results</td>
</tr>
</tbody>
</table>

**Meningitis Information Verification**  
New York State Public Health Law requires all students to verify that they have received information about meningococcal disease and made an informed decision about immunization. Review this information at [http://on.ny.gov/2Bef4pj](http://on.ny.gov/2Bef4pj)

**Meningitis Waiver**

I have read the information regarding meningococcal meningitis disease. I acknowledge the risks of not receiving the vaccine and have decided not to obtain the vaccine. (Sign & Date; Under 18, Parent/Guardian signs.)

**Signature**  
Date

---

**Recommended Vaccines**

<table>
<thead>
<tr>
<th>Vaccination</th>
<th>Vaccine Date(s) (Month/Day/Year)</th>
</tr>
</thead>
</table>
| Hepatitis A | #1  
#2 |
| Hepatitis B | #1  
#2  
#3 |
| HPV | #1  
#2  
#3 |
| Influenza (date of most recent dose) |  |
| Polio |  |
| Chickenpox (Varicella) | #1  
#2  
Or year of chickenpox |
| Tetanus | Circle:  
Td  
Tdap |

**Medical Provider Completes**

**Pratt Institute Office of Health and Counseling**  
200 Willoughby Avenue, Willoughby Hall  
Brooklyn, NY 11205  
Phone: 718-399-4542  
Fax: 718-399-4544  
health@pratt.edu

**An official stamp and/or authorized signature from a healthcare provider must appear on this form or it will not be accepted.**

**Medical Provider Signature/Stamp (MD/DO/NP/PA/RN)**  
Date

**Address**

City  
State  
Zip  
Phone number

---

**Upload completed forms at [www.pratt.edu/healthevaluation](http://www.pratt.edu/healthevaluation)**

1 of 3
Tuberculosis Screening 2019-2020

Name: ____________________________ Last          First          MI

Date of Birth: __/__/____          Pratt ID #: __________________________

Please complete one of the following tests for tuberculosis. Reports must be attached if a
Quantiferon/T-Spot test or chest x-ray is completed. Testing and results must be from the last 12 months.

<table>
<thead>
<tr>
<th>PPD Date Placed:</th>
<th>PPD Date Read:</th>
<th>Measurement in mm indication: _____ x _____ mm</th>
</tr>
</thead>
</table>

OR

QFT-G or T-Spot Result:
- Positive
- Negative
- Equivocal

Quantiferon-TB Gold or T-Spot Result Date:

MUST ATTACH LAB REPORT

If PPD results are 10mm or more, or Quantiferon-TB Gold or T-SPOT results are positive, a chest x-ray is REQUIRED.

<table>
<thead>
<tr>
<th>Chest X-Ray Date:</th>
<th>Chest X-Ray Result:</th>
</tr>
</thead>
</table>

MUST ATTACH REPORT

If negative CXR and positive PPD/Lab Result, did the patient complete a course of INH or other TB Treatment?  ○ Yes  ○ No

If yes, name & dose of medication: __________________________

Date Range of Treatment: ___________  How many months did student take medication? ___________ (# of months)

An official stamp and/or authorized signature from a healthcare provider must appear on this form or it will not be accepted.

Medical Provider Signature/Stamp (MD/DO/NP/PA/RN)  Date

______________________________
Address

______________________________
City  State  Zip  Phone number

Upload completed forms at www.pratt.edu/healthevaluation
Physical Examination 2019-2020

Name: ___________________________ Last  First  MI

Date of Birth: __/__/____   Pratt ID #: ___________________________

Height __ ft __ in    Weight _____ lb

Blood Pressure _____ / _____    Pulse _____ b/min

Sex ☐ Male ☐ Female

Vision L 20/_____   R 20/_____   Vision Corrected? ☐ Yes ☐ No

Medical

Normal

Abnormal Findings

- Appearance
- Eyes/ears/nose/throat
- Lymph nodes
- Heart/Vascular
- Pulse
- Abdomen
- Genitourinary
- Skin
- Neurological
- Lungs/Chest
- Psychiatric
- Musculoskeletal

Date of physical examination: (mm/dd/yyyy) ___________________________

Do you have any recommendations regarding the care of this student or other conditions needing follow up at school? ☐ YES ☐ NO

Diagnosis/Treatment/Recommendation: ___________________________

Allergies (medication, food, environment, etc): ___________________________

Medications (Regularly taken or required - include birth control): ☐ YES ☐ NO

If YES, list medications and dosage required: ___________________________

Please list any significant medical/surgical history: ___________________________

Special dietary requirements: ___________________________

Has patient ever been treated for psychological problems, substance abuse, or eating disorder? ☐ YES ☐ NO

If YES, please explain: ___________________________

Sports Clearance (choose one)

☐ Cleared for all sports without restriction

☐ Cleared for all sports with restriction and recommendations for further evaluation or treatment for: ___________________________

☐ NOT CLEARED

An official stamp and/or authorized signature from a healthcare provider must appear on this form or it will not be accepted.

Medical Provider Signature/Stamp (MD/DO/NP/PA) ___________________________

Date ___________________________

Address ___________________________

City  State  Zip  Phone number ___________________________

Upload completed forms at www.pratt.edu/healthevaluation