Students cannot register for classes until they have fulfilled all health evaluation requirements.

Immunization Record

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

Student Completes

Name: _____
Last First MI

Date of Birth: ____/____/____ Pratt ID #: _____
Month Day Year

Emergency Contact: _____
Name Relationship 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 persuant to this authorization.

_____
Parent/Guardian Signature Relationship Date

Medical Provider Completes

Required Vaccines

Must be completed and signed by a healthcare provider or have attached immunization records from previous school, healthcare provider, or government agency. Proof of COVID-19 vaccination is submitted separately. See instructions page for more information.

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

Vaccinations	Vaccine Date Month/Day/Year	Or Attach Serology Results
2 MMRs (measles, mumps, & rubella vaccine) 1st dose after 1st birthday; 2nd dose at least 28 days later. **OR individual vaccines below**	#1 #2	Must attach lab results
2 Measles 1st dose after 1st birthday; 2nd dose at least 28 days after	#1 #2	Must attach lab results
1 Mumps After 1st birthday		Must attach lab results
1 Rubella After 1st birthday		Must attach lab results

Meningitis Information Verification **REQUIRED**

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 Please choose one option and complete.

☐	**Meningitis (within 5 years)**	**Vaccination Date:** ____/____/____ **Circle:** MenACWY MPSV4 MenB
☐	**Meningitis Waiver**	I have read the information regarding meningicoccal 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

Vaccination	Vaccine Date(s) (Month/Day/Year)		
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 chicken pox
Tetanus			
	Circle: Td Tdap		

Must be completed in full. 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

Tuberculosis Testing

Pratt Institute Health Services
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: ____/____/____ Pratt ID #: _____
Month Day Year

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. A BCG vaccination does not exempt students from the testing requirement.

PPD (Skin Test)	
Date placed	____/____/____ Month Day Year
Date read	____/____/____ Month Day Year
Measurement in mm induration	_____ x _____ mm
Result (Circle one)	Positive Negative

OR

QuantiFERON-TB Gold or T-Spot (Blood Test)			
Date of test	____/____/____ Month Day Year		
Result (Circle one)	Positive	Negative	Equivocal
MUST ATTACH REPORT FOR QFT-G/T-SPOT TEST			

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

Chest X-Ray Date:	Chest X-Ray Result:
	MUST ATTACH CHEST X-RAY 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)**

Must be completed in full. 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

Physical Examination

Pratt Institute Health Services
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: _____/_____/_____ Pratt ID #: _____
Month Day Year

Height	_____ **ft** _____ **in**	**Weight**	_____ **lb**	**Sex**	☐ Male ☐ Female	**Hearing**	
Blood Pressure	_____/_____	**Pulse**	_____ b/min	**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 must be within last 6 months: (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

Must be completed in full. 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