Health Evaluation Packet

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.

Health Services 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://www.pratt.edu/about/offices/student-affairs/health-services/immunization-information/](https://www.pratt.edu/about/offices/student-affairs/health-services/immunization-information/)

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 email account.

4. Once Health Services has fully reviewed and accepted your Health Evaluation Packet, an email will be sent to your Pratt email 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. A BCG vaccination does not exempt students from this requirement.

- **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.

- **Check that each form has been completed in full and your medical provider has signed or stamped every form in the designated box.**
Students cannot register for classes until they have fulfilled all health evaluation requirements.

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

Immunization Record

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 pursuant to this authorization.

Parent/Guardian Signature ____________________________ Relationship ____________________________ Date ____________________________

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(s) (Month/Day/Year) Or Attach Serology Results

<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></td>
<td>#2</td>
<td></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></td>
<td>#2</td>
<td></td>
</tr>
<tr>
<td>1 Mumps After 1st birthday</td>
<td></td>
<td>Must attach lab results</td>
</tr>
<tr>
<td>1 Rubella After 1st birthday</td>
<td></td>
<td>Must attach lab results</td>
</tr>
</tbody>
</table>

Recommended Vaccines

Vaccination Vaccine Date(s) (Month/Day/Year)

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

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/2Be54pj Please choose one option and complete.

☐ Meningitis (within 5 years)

Vaccination Date: ____/____/____

Circle: MenACWY MPSV4 MenB

☐ 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 ____________________________

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

Address ____________________________

City ____________________________ State ____________________________ Zip ____________________________ Phone number ____________________________

Upload completed forms at www.pratt.edu/healthevaluation
## Tuberculosis Testing

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

### PPD (Skin Test)

<table>
<thead>
<tr>
<th>Date placed</th>
<th>/ / ___</th>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date read</td>
<td>/ / ___</td>
<td>Month</td>
<td>Day</td>
<td>Year</td>
</tr>
<tr>
<td>Measurement in mm induration</td>
<td>_____ x _____ mm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Result (Circle one)</td>
<td>Positive  Negative</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Quantiferon-TB Gold or T-Spot (Blood Test)

<table>
<thead>
<tr>
<th>Date of test</th>
<th>/ / ___</th>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Result (Circle one)</td>
<td>Positive  Negative  Equivocal</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**MUST ATTACH REPORT FOR QFT-G/T-SPOT TEST**

If PPD results are 10mm or more, or Quantiferon/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 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)

### Upload completed forms at www.pratt.edu/healthevaluation

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**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.**

<table>
<thead>
<tr>
<th>Medical Provider Signature/Stamp (MD/DO/NP/PA/RN)</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
</tbody>
</table>

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

Name: ____________________________

Date of Birth: ______/____/____

Pratt ID #: ______________________

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

Upload completed forms at www.pratt.edu/healthevaluation

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 ________________________________