KEAN
UNIVERSITY
www.kean.edu

School of Health and Human Performance (HHP)
D'Angola Building – D221
908-737-0650

HEALTH RECORD FORM

(Required for entrance into the Athletic Training majors)

Directions:

1. The completed health record is required and must be favorably reviewed for final admission. All information herein is confidential and will not be released without the applicant's written permission.
2. Kindly report in writing to the University Health Service any serious illness or accident requiring medical attention which occurs between the completion of this record and the beginning of classes.
3. Please return this form completed to Athletic Training Program Coordinator or faculty. Acceptance of this form by the department does not necessarily clear the student for participation in the Athletic Training Major Program.
4. Falsifying of any information on this form may be grounds for dismissal from the Athletic Training Major Program.

NAME: (✓one): _______Mr. _____Ms._____Mrs.

First:____M.I.:___Last:____

Street or P.O. Box Address:____

City:____State:_______________________Zip Code:_____________________

Home Phone #:_______________________________ Cell Phone #:_________________________

Kean Email Address:____ Alternate Email Address:_______________________

Names and phone numbers of at least three (3) people who can be reached should an emergency occur:

1. Name_______________________________Relationship___________________________Phone_________________________________

2. Name_______________________________Relationship___________________________Phone_________________________________

3. Name_______________________________Relationship___________________________Phone_________________________________

PARENTAL PERMISSION: The law requires that parental permission be obtained in the event that medical procedures become necessary on minors. However, no operation will be performed, except in an extreme emergency, without our attempting to reach and fully inform the parent, guardian, or spouse.

I give permission for such emergency diagnostic, therapeutic, or operative procedures as may be deemed necessary by qualified medical personnel for my son/daughter/wife/husband.

Parent, Guardian, or Spouse's Signature____

Relationship:____Date____

Note: The student and not the University is financially responsible for any hospital expenses and for the treatment by a physician, even though he/she may have been taken there in an emergency by someone from the University. The student is strongly urged to apply for the medical reimbursement insurance offered at nominal cost at time of registration.

Medical History:

1. At what age did you have any of the following:

________arthritis	________heart problems	________nervous or mental disorders
________asthma	________hepatitis	________polio
________back problems	________high blood pressure	________rheumatic fever
________bronchitis	________kidney problems	________sinusitis
________diabetes	________malaria	________skin disorders
________epilepsy	________meningitis	________tonsillitis
________fainting spells	________migraine	________tuberculosis

________other____

2. Do you consider yourself physically able to participate in physical education including swimming?________
If not, explain:____

3. Have you had any:______________limitation in motion or___________service- connected disability?
Please detail:____

4. Do you use:_____________wheelchair_____________crutches_______________artificial limbs?

Personal History: Have you had or do you have you now:

________frequent or severe headaches	________any reaction to serum, drug, or medicine
________glasses or contact lenses	________any allergies
________hearing aid	________smoking habit
________frequent cough	________a ten (10) pound or more weight change
________intolerance to any food	________frequent episodes of feeling blue
________painful or trick joints	________loss of memory or amnesia
________any problems with your skin	________unexplained headaches or pain
________nervous trouble of any sort	
________an admission to a psychiatric unit	

If you checked any of the above, please explain:____

Family History:

	Age if living	Present State of Health	Age of Death	Cause of Death
Father:				
Mother:				
Brother:				
Sister:				
Spouse:				
Children:				

Has any blood relation (grandparent, parent, brother, sister, daughter, son) had:

________convulsions, epilepsy (fits)	________diabetes
________fainting spells	________high blood pressure
________nervous or mental disorders	________committed suicide
________tuberculosis	________any other fatal illness

If you checked any of the above, please explain:____

I CERTIFY THAT I HAVE REVIEWED THE FOREGOING INFORMATION SUPPLIED BY ME AND THAT IT IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE

Student's Signature____ **Date:**______________________________

Medical Examination: To be completed by the student's physician:

To The Physician: The bearer of this form is applying for admission to the Athletic Training Major Program at Kean University. Please review his/her history and complete this portion of the form. This information will be kept confidential.

Patient's Name:____Patient's Date of Birth:_______________________________

Height: _______________ Build: Slender _______________
Weight: _______________ Medium _______________
B.P: _______________ Heavy _______________
Pulse: _______________ Obese _______________

Distant Vision: Right 20/ ______ corrected to: 20/________
Left 20/ ______ corrected to: 20/ _______
Color blindness:________________________________
Hearing: Right__________Left__________________

Check each item where abnormality occurs:
________1. Head, face, ears, eyes, scalp
________2. Nose and sinuses
________3. Mouth and throat (tonsils)
________4. Neck, thyroid gland, and lymph nodes
________5. Lungs and Chest (including breast)
________6. Heart (size, sound, and rhythm)
________7. Abdomen (including hernia)
________8. Anus, rectum (hemorrhoids pilonidal cysts)
________9. Endocrine system
________10. Genito- urinary system
________11. Spine, extremities, feet (strength, range of motion, posture, scoliosis)
________12. Skin (including identifying body marks, scars, tattoos, acne)
________13. Neurologic

Describe any abnormality checked above:____
____

Diagnosis of any abnormality:____

Does applicant have any physical condition which may interfere with required physical education program (including swimming):
________If so, describe:____

If applicant has any handicap or disability, is he/she known to the New Jersey Commission for Rehabilitation: ____________If so, give counselor's name and location:____
____

Please evaluate applicant's emotional status:____

Has applicant consulted a physician during the past year?____

If so, for what reason(s) ____

How long have you known this applicant?____

To your knowledge, has applicant ever had a convulsion or had epilepsy?____________________________________

Please explain current status:____

(Please continue health record on next page)

The results of the following tests must be dated within the year prior to applicant's admission. Please return this form only when all results are indicated. All items are required for admission.

CBC and Lipid panel: Please attach to physical form

Urinalysis: Color: ______________________________

Specific gravity: ______________________________

Reaction: ______________________________

Albumin: ______________________________

Sugar: ______________________________

Microscopic: ______________________________

Immunizations: Tetanus Toxoid: 1.____________________2.___________________3.____________

or booster (if given within the past 5 years): ______________________________

Sensitivity tests: Tuberculin test (INTRADEMAL ONLY: PATCH NOT ACCEPTED)
Test must be done within the year prior to applicant's entrance to college:

Date:______________________________

Name of x-ray service:______________________________

Result: ______________________________

The state requires the appropriate documents from all students to remain enrolled in a state university.

All students born after 12/31/56: Proof of **two measles vaccines, one mumps vaccine, and one rubella vaccine (MMR)**, all administered after your first birthday and after 12/31/67. The two measles vaccines must have been administered at least one month apart. If records are unavailable, you can take a blood test (Antibodies IgG) to prove immunity. If non-immune, the state requires you to receive the vaccine(s).

Measles 1. __________________ 2. ______________________
Date Date

Mumps Date 1. ___________________
Date

Rubella Date 1. ___________________
Date

All new students taking 12 or more credits: Proof of the **three-dose hepatitis B series** (or two-dose adult series as notated by the physician). If records are unavailable, you can take a blood test (Surface Antibodies) to prove immunity. If non-immune, the state requires you to receive the series.

Hepatitis B series 1. ____________________ 2. ___________________ 3. ____________________
Date Date Date

Print or Stamp
Physician's name:
Address:
Phone:

I certify that I am a physician legally qualified to practice medicine, and that I find the applicant neither mentally or physically disqualified from performance activities as noted above.

Date:______________________________Signature of Physician______________________________

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