

# THE SAGE COLLEGES

**To ensure that this form is complete:**

1. Complete pages 1 and 2 before going to your Health Care Provider. **\*\*SIGN the Authorization for Treatment below.**
2. Bring this form to your Provider for a physical exam.
3. Have your Health Care Provider complete **REPORT OF PHYSICAL EVALUATION & STUDENT IMMUNIZATION FORM**
4. Be sure that page 2, 3 & 4 are signed by your Health Care Provider
5. **CHECK the appropriate college below and RETURN COMPLETED FORM TO: The Sage Colleges, Wellness Center, Attn: Immunization Coordinator**

**FOR ADMINISTRATIVE PURPOSES ONLY**

Semester: \_\_\_\_\_ Fall  
 \_\_\_\_\_ Spring  
 \_\_\_\_\_ Summer

Entering Year: \_\_\_\_\_

Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_

**Russell Sage College**  
 **Sage Graduate School**  
 65 1<sup>st</sup> Street  
 Troy, NY 12180  
 Phone: 518 244-2261  
 Fax: 518 244-2262

**Sage College of Albany**  
 **Sage After Work**  
 140 New Scotland Ave  
 Albany, NY 12208  
 Phone: 518 292-1917  
 Fax: 518 292-1918

**INFORMATION RECEIVED IS CONFIDENTIAL AND WILL NOT JEOPARDIZE YOUR ACCEPTANCE STATUS OR ACADEMIC STANDING** Please Print

\_\_\_\_\_  
 Last Name First Name Middle Date of Birth

\_\_\_\_\_  
 Telephone No. ( ) Student ID #

\_\_\_\_\_  
 Home Address (Number and Street) City or Town State Zip Code

\_\_\_\_\_  
 Name and Address of Next of Kin

Type of Insurance Policy: Name of Policy \_\_\_\_\_

Family  Student  Other  Policy Number \_\_\_\_\_

**Authorization for Treatment:** I DO HEREBY AUTHORIZE THE SAGE COLLEGE TO PROVIDE FIRST AID TREATMENT AND IN CASE OF EMERGENCY, I AUTHORIZE THE TRANSPORTATION INVOLVED AND THE TREATMENT NECESSARY BY A PRACTITIONER AND/OR AT A HOSPITAL. I SHALL ASSUME ANY EXPENSES WHICH ARISE.

\*\*SIGNED \_\_\_\_\_  
 (Student)

\*\*SIGNED \_\_\_\_\_  
 (Parent or Guardian if Student is under 18 years of age)

**MEDICAL HISTORY**

A. Please check any condition which you or a close family member has or has had. Indicate the relationship.

	Self			Family		Relationship
	Y	N		Y	N	
Alcoholism						
Breast Disease						
Cancer						
Elevated Cholesterol						
Diabetes						
Genetic or Birth Defect						
Heart Attack						
High Blood Pressure						
Sickle Cell Trait or Disease						
Stroke						
I am adopted Yes ___ No ___						

B. Check Yes or No below if you have ever had any of the following:

	Y	N		Y	N		Y	N
Anemia (Low Iron)			Gallbladder Stones or Disease			Rheumatism or Arthritis		
Asthma			Head Injury w/ Unconsciousness			Scarlet Fever		
Back Problems			Heart Murmur			Severe Weight Gain		
Bronchitis			Hernia			Severe Weight Loss		
Cancer			Infectious Mononucleosis			Sexually Transmitted Disease		
Chicken Pox			Irritable Bowel Disease			Sinus Infection		
Colitis			Jaundice			Skin Disorders		
Depression			Learning Disability			Suicide Attempt		
Diabetes			Liver Disease or Hepatitis			Throat Infections		
Disease/Injury of Joints			Menstrual Irregularities			Thyroid Abnormalities		
Ear Infections			"Nervous" Stomach			Ulcers (Stomach or Duodenal)		
Eating Disorder			Ovarian Cyst			Urinary Tract or Kidney Infections		
Epilepsy/Convulsions/Seizures			Pelvic Infections			Uterine Abnormalities		
Eye Problems			Pneumonia			Vaginal Infections		
Frequent Headaches			Rheumatic Fever			Varicose Veins		

1. List any surgery/operations you have had and dates: \_\_\_\_\_  
 Remarks or additional information \_\_\_\_\_  
 \_\_\_\_\_  
 (Use additional sheet if necessary)

2. Have you been hospitalized overnight? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Why? \_\_\_\_\_

3. Do you experience depressions, anxiety, or other emotional problems? Yes \_\_\_\_\_ No \_\_\_\_\_

4. Have you received counseling at any time? Yes \_\_\_\_\_ No \_\_\_\_\_ Dates \_\_\_\_\_  
 For what? \_\_\_\_\_  
 Are you currently receiving counseling? Yes \_\_\_\_\_ No \_\_\_\_\_ Where \_\_\_\_\_  
 For what? \_\_\_\_\_

5. Please list all medications currently being taken with dosage, frequency and condition for which it is being taken:

Medication	Dosage	Frequency	Condition

6. List ALL ALLERGIES you have:  
 Medications: \_\_\_\_\_

Foods: \_\_\_\_\_

Bees/Insects: Yes \_\_\_\_\_ No \_\_\_\_\_ Do you carry an EPI-PEN? Yes \_\_\_\_\_ No \_\_\_\_\_

Environmental: \_\_\_\_\_

7. Tobacco use: Yes \_\_\_\_\_ No \_\_\_\_\_ Type/Amount \_\_\_\_\_

8. Alcohol use: Yes \_\_\_\_\_ No \_\_\_\_\_ Amount \_\_\_\_\_ Drug use? Yes \_\_\_\_\_ No \_\_\_\_\_ Type/Amount \_\_\_\_\_

9. Do you wear glasses? \_\_\_\_\_ Contacts? \_\_\_\_\_

\_\_\_\_\_  
 Student's Signature

\_\_\_\_\_  
 Clinician's Signature (Acknowledge Review)

\_\_\_\_\_  
 Date

## REPORT OF PHYSICAL EVALUATION

Name: _____	DOB _____
Height: _____	Weight: _____ BMI (optional): _____
	Pulse: _____ BP: _____
Vision: R 20/_____ L/20 _____	corrected: Y N      Urinalysis: Glucose ____ Protein ____ Micro ____
Blood work (as applicable) Cholesterol _____ Hg _____ Hct _____	

	Normal	Abnormal Findings	Initials
MEDICAL			
Head			
Eyes (lids, conjunctivae, pupils & ocular motion)			
Ears			
Nose/Throat			
Lymph Nodes (Cerv., Ax., Ing.)			
Heart			
Pulses			
Lungs/chest			
Breasts			
Abdomen/Viscera (include hernia)			
Skin			
NEUROLOGIC:			
Gait, Romberg, Muscle Strength/tone, Sensory, Tremor			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

Yes	No	
		Any recommendations for special dietary requirements or limitation of physical activity?
		Is this individual under care for a chronic condition or serious illness? If yes, please enclose further information.

**Upon completion of a complete physical examination I have found this student capable of participating in a full program of college study, including participation in intercollegiate sports.**

Name of Clinician: (print/type) _____	Date: _____
Address: _____	Phone: _____
Signature of Physician _____	

