ASU NYSP

2025 Albany State Youth Enrichment Program

Medical Examinaton Record

Intended for NYSP Participation Only

This confidential information should be made available only to the medical coordinator and physician.

Enrollee name _____ **Telephone** _____
Last First MI

Address _____ **M** ❑ **F** ❑ **Age** _____
Street Address

_____ **Birthdate** _____/_____/_____
City State Zip Code Month Day Year

Name of parent or guardian _____

Address of parent or guardian _____

Telephone: Home _____ **Work** _____

Emergency Contact

Name _____ **Relationship** _____

Telephone: Home _____ **Work** _____

Address _____
Street Address

_____
City State Zip Code

Family doctor _____ **Telephone** _____

ATTENTION MEDICAL COORDINATOR:

Referral: A youth's parents or guardian must be informed of any health problem discovered during the screening process or during the course of the project. An appropriate health-care agency also will be informed if the parents of guardian consent.

Follow-up: When a health problem is discovered, the institution shall pursue the matter until the problem receives proper treatment or until all reasonable opportunities for such treatment have been exhausted. Institutional responsibility for preexisting medical problems or for problems unrelated to NYSP participation ends with the conclusion of the project.

REFERRAL AND FOLLOW-UP PROCEDURE

Parents or guardian and/or health authorities notified of child's health deficiency **Yes** ❑ **No** ❑

Means of notification: Personal Contact ❑ **Telephone** ❑ **Letter** ❑ **Date of notification** _____

Noticeable improvements as of:

_____	_____	_____
Date	Yes	No
_____	_____	_____
Date	Yes	No

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Height _____ Weight _____ Pulse _____ B/P _____

List Allergies _____ Hemophilia _____ Other _____

	Normal	If Abnormal, Describe Here	Follow-Up Yes	Follow-Up No
Ears (hearing, absence or cerumen)				
Eyes (reflexes, movements, visual acuity)				
Nose, Throat, Sinuses				
Gums				
Teeth				
Neck				
Lungs				
Breast				
Lymph Nodes				
Heart				
Absence of Hernia				
Back				
Skin				
Bones, Joints, Muscles				
Nervous System				

OPTIONAL

Chest X-ray				

Sickle Cell Prep _____ Urine Albumin _____ Urine Sugar _____ Hb. _____

Immunization Record:

Tetanus _____ (Date) Booster Needed Yes ❑ No ❑

Diphtheria _____ (Date) Booster Needed Yes ❑ No ❑

Polio _____ (Date) Booster Needed Yes ❑ No ❑

Medical History (including current medications taken) _____

_____

General physical condition _____

May participate in program Yes _____ No _____

Additional comments or recommendations _____

_____

Physician Signature: _____