Office of Health Services
695 Park Ave., 307 North Building
New York, New York 10065
212.772.4800 / 4801

www.hunter.cuny.edu

HUNTER
The City University of New York

For Office Use
Date Rec'd: ________________
Rec'd by: ________________
Exp: ________________

Medical Record

In order to obtain your Physical Activity Card, please have this form filled out by your Physician and submit it to the Office of Health Services, 307 North to recommend your participation in physical activity and recreational programs. Please note that you will need to show a copy of your Hunter College student ID.

Part 1: Student/Staff Information *To be completed by the student/staff.*

name of student/staff: ____
Please print. *last name* *first name* *m.i.*

date of birth	social security number	daytime phone #	email address
____/____/______ mm dd yyyy	___ ___ ___ – ___ ___ – ___ ___ ___ ___	( ) ____________	____________

address: ____
Please print. *street address* *city* *state* *zip code*

emergency contact: ____
Please print. *name* *relationship* *phone number*

Instructions to the student/staff: *Please check all that apply.*

☐ Student ☐ Faculty ☐ Alumni ☐ Undergraduate ☐ Graduate ☐ Day ☐ Evening
☐ Male ☐ Female ☐ Single ☐ Married

Condition	Yes	No	Condition	Yes	No
Allergies			Intestinal or Stomach Disorder		
Anemia			Pelvic Infection		
Anxiety			Respiratory Disorder		
Cancer, Cysts, Tumor, etc.			Rheumatic Fever		
Depression			Seizure Disorder		
Diabetes			Sexually Transmitted Disease		
Dizziness, Fainting			Skin Disorder		
Headaches			Thyroid Disorder		
Hearing Problems			Tuberculosis or Treatment or Prevent		
Heart Problem			Urinary Infection		
High Blood Pressure			Other		
1. Do you have health insurance?					
2. Have you ever had a serious illness?					
3. Have you ever had a broken bone?					
4. Have you ever had an operation?					
5. Are you taking any medications?					
6. Are you currently being treated by a Physician for any medical condition?					

Explain all YES answers: *(please give dates)* ____
____
____

I hearby certify that the above information is correct to the best of my knowledge.

student/staff signature: ________________________ **date:** ____________

Part 2: Physical Examination ***To be completed by the Physician.***

Note: *Any corrections, or ink discrepancies of original information be signed and stamped by the Physician.*

Height (in)	Vision O.S.
Weight (lbs)	Vision O.D
B/P	Other

	Normal	Abnormal	Not Examined
1. Head, Ears, Eyes, Nose, Throat	☐	☐	☐
2. Neck	☐	☐	☐
3. Skin	☐	☐	☐
4. Lungs	☐	☐	☐
5. Cardiovascular	☐	☐	☐
6. Breasts	☐	☐	☐
7. Abdomen	☐	☐	☐
8. Musculoskeletal	☐	☐	☐
9. Lymphatic System	☐	☐	☐
10. Neurological	☐	☐	☐
11. Psychiatric	☐	☐	☐
12. GU	☐	☐	☐
13. Rectal	☐	☐	☐
Summary:			

Is this student/staff member currently under a physician's care or taking medication? ☐ **YES** ☐ **NO**

Please specify: ______________________________

Is this student/staff member currently being monitored for any of the following illnesses?

1. Mental ☐ **YES** ☐ **NO**
2. Physical ☐ **YES** ☐ **NO**

Please specify: ______________________________

RECOMMENDATIONS FOR PHYSICAL ACTIVITY

☐ Cleared or Full Participation ☐ Limited *(Please explain below.)* ☐ Debarred

comments: ______________________________

____

____

examiner's name and title: ______________________ **date:** ______________

address: ______________________________

____

signature: ______________________________

PHYSICIAN'S STAMP