Precollege Immersion Program
Medical Information

Return by May 15, 2025

4 ' 2 /4, 5 3' /5 4 *All information is required, and entries must be written in English. Please print*

Last Name _____ First Name _____ MI_____

Preferred Name_____ DOB _____

Home Address _____

Home Phone (_____)_____-_____Cell Phone (_____)_____- _____

Email_____Guardian's Email _____

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1. Name_____Relationship_____Phone (_____)_____- _____

2. Name_____Relationship_____Phone (_____)_____- _____

Please provide the name and contact information of the individual who can travel to Pace University's NYC campus in case of anemergency (if different than one or both student's guardian(s) listed above).

1. Name_____Relationship_____Phone (_) __ -

/54 3 */ '2 / 5 (To be Completed by Parent/Guardian)

Drug Allergies _____

Food Allergies/Intolerance _____

Other Dietary Restrictions/Needs (e.g. vegan, kosher)_____

Student Requires EpiPen?_____YES_____NO Student Trained in Use?_____N/A_____YES_____NO

Medications ***(Please Include ALL Prescription Medications and Over-the-Counter Medications Taken Daily)*** _____

Past Medical History _____

Family Medical History _____

Travelled Out of the United States in the Last 12 Months?_____Yes_____No

/54 '2 ' 5 /* '3/4' /54 (To be Completed by Provider ONLY)

Height _____ Weight _____ BMI _____ Blood Pressure _____ Heart Rate _____

Vision R_____L_____(Corrected/Uncorrected) Hearing_____(Whisper Acceptable)

SYSTEM	SATISFACTORY	UNSATISFACTORY	

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VACCINATION DATES: Two Measles vaccinations, one Mumps vaccination, and one Rubella vaccination must have been given **after the first birthday.** Please have your health care provider indicate the dates appropriately and certify the form below:

MMR Dose #1:__/___/____ Measles Dose #1: ____/____/___ Rubella Dose #1:___/____/_____

MMR Dose #2:__/___/____ Measles Dose #2: ____/____/___ Rubella Dose #2:__/____/_____

MEDICAL HISTORY: If you have history of contracting either Measles or Mumps disease, please have your health care provider indicate the date(s) appropriately and certify the form below:

Rubella Disease: ___/___/___ Measles Disease:_____/___/____ Mumps Disease:____/_____/_____

EXEMPTION FROM MEASLES, MUMPS, and RUBELLA VACCINATION (studd72.94Tm nBT(c)-662 790 9.-17(P)-4(S)8(,)]BTW* nl

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