



## Health Leave of Absence: MEDICAL CARE PROVIDER REPORT

**INSTRUCTIONS:** This student is applying to return to Cornell University after taking a Health Leave of Absence (HLOA).

- **STUDENT:** complete PART 1.
- **MEDICAL CARE PROVIDER:** complete PARTS 2, 3, and 4
  - If necessary, use the back of this page or attach documentation to expand on your responses and record additional comments regarding the student and her/his ability to function safely, stably, and successfully as a full-time university student at this time.
  - Please send: **ATTN: HLOA/Health Records** – by **FAX:** 607.255.0269 or by **MAIL:** use above address.

### PART 1 Student information

Student name \_\_\_\_\_ Date of birth \_\_\_\_\_  
Medical condition that precipitated taking HLOA \_\_\_\_\_

### PART 2 Medical care provider information / signature

Name \_\_\_\_\_ Profession licensed as \_\_\_\_\_  
Signature \_\_\_\_\_ License number \_\_\_\_\_  
Date \_\_\_\_\_ State of licensure \_\_\_\_\_

### PART 3 Medical care provider assessment

What is your assessment of the current status of the student's condition? ☐ Good ☐ Fair ☐ Poor

Do you have any reservations regarding this student's full-time enrollment at Cornell University in the upcoming semester?

☐ No reservations ☐ Reservations: \_\_\_\_\_  
\_\_\_\_\_

What are your recommendations for the student's ongoing care upon returning to school? \_\_\_\_\_  
\_\_\_\_\_

### PART 4 Physical exam

Height \_\_\_\_\_ Weight \_\_\_\_\_ BMI \_\_\_\_\_ Pulse \_\_\_\_\_ Blood pressure \_\_\_\_\_  
General appearance \_\_\_\_\_

Exam	Finding	Comments / Abnormals
Eyes	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Ears	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Nose	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Mouth/Throat	<input type="checkbox"/> Normal <input type="checkbox"/> Dental erosion <input type="checkbox"/> Parotid gland enlargement	
Neck	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Heart	<input type="checkbox"/> Normal <input type="checkbox"/> Bradycardic <input type="checkbox"/> Murmur present <input type="checkbox"/> Tachycardic	
Lungs	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Abdomen	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Scaphoid <input type="checkbox"/> Bloating	
Skin	<input type="checkbox"/> Normal <input type="checkbox"/> Dry <input type="checkbox"/> Pale <input type="checkbox"/> Lanugo <input type="checkbox"/> Yellowing <input type="checkbox"/> Hyperpigmentation <input type="checkbox"/> Alopecia <input type="checkbox"/> Excoriations on hands <input type="checkbox"/> Pressure sores <input type="checkbox"/> Self-inflicted wounds	
Extremities	<input type="checkbox"/> Normal <input type="checkbox"/> Edema <input type="checkbox"/> Mottling <input type="checkbox"/> Cool <input type="checkbox"/> Muscle wasting	
Neurologic	<input type="checkbox"/> Normal reflexes <input type="checkbox"/> Abnormal	