



Medical Records

(Please retain a copy for your files.)

Please complete both sides and return to:

Office of Health Services
Queens and Manhattan campuses
8000 Utopia Parkway
Queens, NY 11439
Tel (718) 990-6360
Fax (718) 990-2368
www.stjohns.edu

Staten Island campus
Campus Center
300 Howard Avenue
Staten Island, NY 10301
Tel (718) 390-4447
Fax (718) 390-4480

Please print.

Name: _____ Date of Birth: _____

Address: _____ Home Tel: _____

Student ID #: _____

Emergency Contact Name: _____ Tel: _____

Medical History (Include dates if possible)

Allergy: Drugs: _____ Allergy: Other: _____

Allergy: Foods: _____ Kidney Disease: _____

Heart Disease: _____ Chicken Pox: _____

Diabetes: _____ Asthma: _____

Hypertension: _____ Seizure Disorder: _____

Hypoglycemia: _____ Other: _____

Have you had any serious accidents? Yes No Nature of injury: _____

List of operations and dates: _____

Do you take prescribed medications on a regular basis? Yes No

If yes, please list: _____

Do you have a physical, learning or other disability of which the University should be aware in order to help you achieve your educational goals? Yes No If yes, please describe: _____

Health insurance is **MANDATORY** for all resident and international students.

CONSENT FOR MEDICAL TREATMENT: The law requires that parental permission be obtained so that medical treatment can be administered to students under the age of 18.

I hereby grant permission for medical evaluation, treatment and/or hospitalization in case of illness or accident for myself/son/daughter/guardian. I grant permission for hospital admission and for administration of anesthetics and necessary operative procedures in an emergency. I give permission for the release of information concerning my/his/her medical condition to other responsible University officials when necessary.

Name of Student: _____ Student ID #: _____

Signature of Parent/Guardian: _____ Date: _____ Tel: _____



Physical Examination

(To be completed by Physician or Health Care Provider.)

Please complete both sides and return to the Health Services Office at the campus of your choice.
For more information:

Office of Health Services
Queens and Manhattan campuses
8000 Utopia Parkway
Queens, NY 11439
Tel (718) 990-6360
Fax (718) 990-2368
www.stjohns.edu

Staten Island campus
Campus Center
300 Howard Avenue
Staten Island, NY 10301
Tel (718) 390-4447
Fax (718) 390-4480

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____
Vision: _____ Right: _____ Left: _____ Corrected: Right: _____ Left: _____

For Allied Health Students only:

Color Vision Screening Normal _____ Abnormal _____

Hearing: _____

Urinalysis Result: _____ Date: _____

Blood Count HCT: _____ HGB: _____ Date: _____

	Normal	Abnormal		Normal	Abnormal
Head, neck, face and scalp	_____	_____	Abdomen	_____	_____
Nose and sinuses	_____	_____	Endocrine System	_____	_____
Mouth, teeth, gingival	_____	_____	Extremities	_____	_____
Ears	_____	_____	Reflexes	_____	_____
Eyes	_____	_____	Musculoskeletal	_____	_____
Lungs, chest and breasts	_____	_____	Lymphatic	_____	_____
Heart	_____	_____	Neurologic	_____	_____
Vascular	_____	_____			

Check one

Tetanus-Diphtheria booster (within the last 10 years) Date: _____ DTaP Date: _____

Tuberculin Skin Test (within six months of date of this exam)

Mantoux: Result: _____ mm induration. Date: _____

IF TUBERCULIN SKIN TEST IS POSITIVE: Chest x-ray required.

Date: _____ Result: _____

Polio series completed: Yes No

Varicella vaccine Dose 1 Date: _____ Dose 2 Date: _____ Disease Date: _____

Hepatitis B vaccine (recommended) Dose 1 Date: _____ Dose 2 Date: _____ Dose 3 Date: _____

Meningococcal vaccine (recommended for students living in the residence halls) Date: _____

Family history (relevant health problems): _____

In your judgment, is there any reason why physical activities would be contraindicated? Yes No
If yes, explain: _____

(Please use name stamp or attach RX with your signature)

Physician's Name (Print): _____ Date of Exam: _____

Registration Number: _____

Address: _____

Tel: _____ Signature: _____

The information contained on this form is accessible only to the professional health staff of the Health Services Office and will not be released without the written authorization of the student or pursuant to a lawfully issued subpoena. The authority to request this information is found in Section 355 of the Educational Law.