# Medical Records

(Please retain a copy for your files.)

## Student Health Services
Queens and Manhattan Campuses  
8000 Utopia Parkway  
Queens, NY 11439  
Tel 718-990-6360  
Fax 718-990-2368  
stjohns.edu

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

Please print.

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date of Birth:</th>
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<table>
<thead>
<tr>
<th>Address:</th>
<th>Home Tel:</th>
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<table>
<thead>
<tr>
<th>Student X #:</th>
<th>Tel:</th>
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<tr>
<th>Emergency Contact Name:</th>
<th>Tel:</th>
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## Medical History (Include dates if possible)

- **Allergy—Drugs:**
- **Allergy—Other:**
- **Allergy—Foods:**
- **Kidney Disease:**
- **Heart Disease:**
- **Chicken Pox:**
- **Diabetes:**
- **Asthma:**
- **Hypertension:**
- **Seizure Disorder:**
- **Other:**

- Have you had any serious accidents?  
  - [ ] Yes  
  - [ ] No  
  - Nature of injury:  

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<tr>
<th>List of operations and dates:</th>
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- Do you take prescribed medications on a regular basis?  
  - [ ] Yes  
  - [ ] No  

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<th>If yes, please list:</th>
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- 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:  

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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.

<table>
<thead>
<tr>
<th>Name of Student:</th>
<th>Student X #:</th>
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<th>Signature of Parent/Guardian:</th>
<th>Date:</th>
<th>Tel:</th>
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Physical Examination

(To be completed by physician or health care provider.)

Please complete and return to Student Health Services at the campus where you are enrolled. For more information:

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300 Howard Avenue
Staten Island, NY 10301
Tel 718-390-4447
Fax 718-390-4480

Student Name: ____________________________ Date of Birth: ____________________________

Student X#: __________________________________ Gender □ Male □ Female

Height: __________ Weight: __________

Blood Pressure: __________ Pulse: __________

Corrected: Right: __________ Left: __________

For Health Sciences Students only:

Color Vision Screening Normal ______ Abnormal ______

Urinalysis Result Normal ______ Abnormal ______ Date: __________

Blood Count HCT: _____________________________ Normal ______ Abnormal ______

HGB: __________________ Date: __________

Head, neck, face and scalp ______ ______

Nose and sinuses ______ ______

Mouth, teeth, gingival ______ ______

Ears ______ ______

Eyes ______ ______

Lungs, chest and breasts ______ ______

Heart ______ ______

Vascular ______ ______

In your judgment, is there any reason why physical activities would be contradicted? □ Yes □ No

If yes, explain ________________________________________________________________

Family history(relevant health problems) ____________________________________________

TB SCREENING

Tuberculin Skin Test (within six months of exam): Date Planted ___/___/___ Date Read ___/___/___

Result: □ Positive □ Negative ______ mm induration

PharmacyD Students Only two step testing necessary: Date Planted ___/___/___ Date Read ___/___/___

Result: □ Positive □ Negative ______ mm induration

or QTF TB Gold Test Date ___/___/___ Result: □ Positive □ Negative Attach QTF Lab Results

*If QTF or PPD Test Positive, Chest X-Ray Required: Date ___/___/___ Result: □ Positive □ Negative

VACCINE RECORD- if blood titers drawn, please attach lab results

Tetanus-Diphtheria Booster: (within 10 years) Date ___/___/___ Tdap Date ___/___/___

Varicella Vaccine: Dose 1 ___/___/___ Dose 2 ___/___/___ or Disease Date ___/___/___

Hepatitis B Vaccine (recommended): Dose 1 ___/___/___ Dose 2 ___/___/___ Dose 3 ___/___/___

Meningococcal Vaccine (recommended after 16th birthday): Date ___/___/___

or Refused □ Attach Meningitis Response Form

MMR (required by NYS Law): Dose 1 ___/___/___ Dose 2 ___/___/___

Polio series completed: □ Yes □ No

Physician’s Name (Print) __________________________________________________________

Signature: __________________________________________ Exam Date ___/___/___

License Number: ____________________________ Physician Stamp: ____________________________

or attach Rx with signature