ST. JOHN'S UNIVERSITY

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

Physical Examination

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

Please complete and upload to the patient portal, fax, mail, or return in person to Health Services at the Queens campus.

Student Name: _____ Date of Birth: _____

Student X #: _____ Gender: ☐ Male ☐ Female

Campus where you are enrolled: (check one) ☐ Queens ☐ Manhattan ☐ Staten Island

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Vision: _____ Right: _____ Left: _____ Corrected: Right: _____ Left: _____

For Health Sciences Students only:

Color Vision Screening Normal _____ **Abnormal** _____

Urinalysis Result Normal _____ Abnormal _____ 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	_____	_____	Genital/Urinary	_____	_____

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

Pharm.D. 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 A Vaccine: Dose 1 ___/___/___ Dose 2 ___/___/___

Hepatitis B Vaccine: Dose 1 ___/___/___ Dose 2 ___/___/___ Dose 3 ___/___/___

Meningococcal ACWY Vaccine within the past 5 years, at age 16 years or older: Date ___/___/___

or Refused ☐ *Attach Meningitis Response Form*

Meningitis B vaccine: Dose 1 __/__/__ Dose 2 __/__/__ Dose 3 __/__/___

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

HPV Vaccine: Dose 1 __/__/__ Dose 2 __/__/__ Dose 3 __/__/__

Polio series completed: ☐ Yes ☐ No

Flu Vaccine: Date ___/___/___

Physician's Name (Print) _____

Signature: _____ Exam Date ___/___/___

License Number: _____ Physician Stamp: _____

or attach Rx with signature

ST. JOHN'S UNIVERSITY

Medical Records

(Please retain a copy for your files.)

Please complete and upload to the patient portal, fax, mail, or return in person to Health Services at the Queens campus.

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

Please print.

Name: _____ Date of Birth: _____

Address: _____ Home Tel.: _____

_____

Student X #: _____

Emergency Contact Name: _____ Tel.: _____

Campus where you are enrolled (check one): ☐ Queens ☐ Manhattan ☐ Staten Island

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: _____

_____

Would you like the Office of Disabilities Services to contact you? ☐ Yes ☐ No

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 X #: _____

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

M1-10732/LR