



ST. JOHN'S UNIVERSITY

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

Physical Examination

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

Complete and upload to the patient portal.

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: _____

Table with 2 columns of body systems (e.g., Head, neck, face, and scalp; Abdomen) and 2 columns of status (Normal, Abnormal).

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 five 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

The information contained on this form is accessible only to the professional health staff of Student Health Services 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.



**ST. JOHN'S
UNIVERSITY**

Medical Records

(Please retain a copy for your files.)

Complete and upload to the patient portal.

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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: _____

If you have a disability and seek reasonable accommodations, please contact the Office of Disability Services (ODS) at disabilityservices@stjohns.edu for more information. You may also visit the ODS website for details about the accommodations process at www.stjohns.edu/life-st-johns/health-and-wellness/disability-services.

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: _____