ST. JOHN'S UNIVERSITY

Club Sports Emergency Contact Information

To be completed before first date of play and submitted to the Campus Recreation Office, Taffner Field House, Room 105.

Athlete's Name: _____ DOB: ___ /___ /___

Sport: _____ Address: _____

City: _____ State: _____ Phone Number: _____

EMERGENCY CONTACT INFORMATION

In an emergency, contact:

_____ _____

(Last) (First) (Phone) (Relationship)

Address:_____ City, State, and Zip:_____

Evening/Weekend Phone:_____ Day Time Phone:_____

Please declare in the spaces provided below any allergies, medication, prior conditions or other pertinent information that would be of important knowledge in a medical emergency.

By signing below I acknowledge that I am releasing this information for the disclosure to and only to appropriate medical officials in the event of an emergency.

Club Sport Participant Signature: _____ Date: _____

ST. JOHN'S UNIVERSITY

Physical Examination

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

Please complete and fax, mail, or return in person to the Health Services Center 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

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

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

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

Medical Records

(Please retain a copy for your files.)

Please complete and fax, mail, or return in person to the Health Services Center 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: _____

_____

_____

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: _____

M1-9190-RM

ST. JOHN'S UNIVERSITY

Campus Recreation
LIABILITY WAIVER

I,_____, acknowledge, agree and represent that:
I understand the nature of activities/programs sponsored by the Campus Recreation Department and represent that I am qualified, in good health and in proper physical condition to participate in such activities/programs.

I fully understand the type of injuries that can occur in and as a result of participation in the activities/programs sponsored by the Campus Recreation Department and that such participation involves risks and dangers of both serious and minor bodily harm including, but not limited to:

- stoppage of breathing
- spinal and neck injuries (which could result in paralysis)
- heart failure
- damage/abrasions to limbs/appendages
- heat stroke/cramps/exhaustion
- stroke
- convulsions
- unconsciousness/fainting
- internal/organ injuries
- permanent disability
- death

These risks may result from my own actions/omissions or actions/omissions of other participants in activities/programs, the equipment involved in the activities/programs, the facility itself, or the negligence of the releases named below. There may be physical/economic risks and all responsibility for losses either not known or readily foreseeable to the Releasees at this time. **I fully accept and assume any and all responsibility for losses, costs and damages that I incur as a result of my participation in any activities/programs associated with Recreational Sports/Wellness and/or Student Life.**

I willingly agree to comply with the stated and customary terms and conditions for participation in any activities/programs sponsored by Campus Recreation. I consent to first aid and emergency medical care, including but not limited to, admission to an accredited hospital for treatment for any injuries that I may sustain while participating in any activities/programs sponsored by Campus Recreation.

I, on behalf of my heirs/assigns/personal representatives/ and next of kin/ hereby release, discharge and covenant not to sue St. John's University, its administrators, agents, officers, employees, students, guests of the Campus Recreation Department, sponsors, or advertisers (each considered one of the "RELEASEES" herein) from all liability, claims, demands, losses, and damages with respect to any and all injuries, disability, death and loss/damage to personal property caused or allegedly caused in whole or in part by the negligence of the releasees or otherwise.

I, on behalf of myself and my heirs/assigns/personal representatives/and next of kin, further agree to indemnify and hold harmless each of the Releasees from any litigation expenses, attorney fees, liability, damages or costs which any Releasees may incur as the result of any claim made in contravention of this Agreement.

I have read this agreement and fully accept its terms. I understand that this Agreement is intended to be a complete and unconditional release of all liability and that, by signing this Agreement, I may be giving up legal rights that I may otherwise have.

_____ _____

Date Signature

_____

If under 18, must be signed by Parent or Guardian