St. John's Preparatory School

21-21 Crescent Street, Astoria, NY 11105
Medical Office
(718)721-7200 ext. 624

ALL INCOMING FRESHMAN STUDENTS MUST HAVE A PHYSICAL EXAMINATION BY US PHYSICIAN

Personal History: Section A

Name _____ Social Security #_____

History of family disease_____

Check below if you have any of the following:

EPIPEN YES_____ NO_____

ASTHMA_____

DIABETES_____

HEADACHES_____

HEART DISEASE_____

KIDNEY DISEASE_____

RHEUMATIC FEVER_____

SEIZURES_____

THYROID DISEASE_____

HEARING PROBLEM_____

SPEECH PROBLEM_____

VISION PROBLEM_____

ORTHOPEDIC PROBLEM_____

SERIOUS ACCIDENT_____ ILLNESS_____

SURGERY_____

CANCER_____

List all childhood diseases you ever had: _____

Are you taking any form of treatment now?_____ Specify_____

Are you taking any medication?_____ Counseling Yes_____ No_____

St. JOHN'S PREPARATORY SCHOOL

IMMUNIZATION RECORDS FOR NEW SCHOOL ENTRANTS

1. MEASLES, MUMPS AND RUBELLA

- MMR #1 MUST BE ADMINISTERED ON OR AFTER THE FIRST BIRTHDAY.
- #2 IS VALID ONLY AFTER 15 MONTHS OF AGE AND THEN AT LEAST 28 DAYS AFTER # 1.

2. HEPATITIS SERIES:

- THERE MUST BE AT LEAST 4 MONTHS BETWEEN 1st AND 3rd DOSE.
- MINIMUM ACCEPTABLE INTERVAL BETWEEN 1st AND 2ND DOSE IS 28 DAYS.
- MINIMUM ACCEPTABLE INTERVAL BETWEEN 2ND AND 3RD DOSE IS 56 DAYS.

3. VARICELLA (CHICKEN POX VACCINE)

- THIS MUST BE ADMINISISTERED ON OR AFTER THE FIRST BIRTHDAY. TWO DOSES ARE RECOMMENDED BUT ONLY ONE DOSE IS REQUIRED

4. MENINGOCOCCAL VACCINE

- THIS VACCINE IS MANDATED FOR ALL 16 YEAR OLDS BY THE DEPARTMENT OF HEALTH. ALL STUDENTS ENTERING SENIOR YEAR MUST RECEIVE AND PROVIDE DOCUMENTATION OF VACCINE BEFORE RETURNING TO SCHOOL IN SEPTEMBER. IF YOUR CHILD HAS HAD A MENNINGOCCAL VACCINE BEFORE 16, THEY WOULD THEN HAVE TO RECEIVE A BOOSTER.

ST. JOHN'S PREPARATORY SCHOOL

IMMUNIZATION RECORDS FOR NEW SCHOOL ENTRANTS

Social Security # _____ Male _____ Female _____

EXCEMPT (DOCUMENTATION MUST BE ATTACHED) -RELIGIOUS_____ MEDICAL_____

DTPd DTaP _____ _____ _____ _____ _____

DT, TD _____ _____ _____ _____ _____

Tdap ADACEL _____ BOOSTRIX _____

POLIO _____ _____ _____ _____ _____

MMR #1 _____ #2_____

MEASLES #1_____ MUMPS #1 _____ RUBELLA #1 _____

#2 _____ #2 _____

HIB _____ _____ _____ _____

HEPATITIS B #1 _____ #2 _____ #3 _____

HEPATITIS A #1 _____ #2 _____ #3 _____

MENINGOCOCCAL TYPE _____ DATE _____ DATE _____

VARICELLA _____ _____ DISEASE _____ DATE _____

HPV _____ _____ _____

MANTOUX _____ RESULT _____

QUANTIFERON _____ RESULT _____

OTHER _____ _____ _____

SIGNATURE OF MEDICAL PROFESSIONAL DATE STAMP

_____ _____

ST. JOHN'S PREPARATORY SCHOOL

School Health New Admission Examination Form

Grade

Student ID #

Social Security #

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Student: Last Name First Name Middle

SEX ◯ Male ◯ Female

BIRTHDAY M D Y / /

Place of Birth: ◯ USA, State: ◯ Country:

Parent/ Guardian: Last Name First Name

Ethnicity: Hispanic Black Am. In. White Asian Other:

STUDENT ADDRESS: Apt/Fl ZIP

Telephone No. Work ( ) Home ( )

School District | School Name ◯ Public JHS/IS ◯ Public HS ◯ Non-Public

TO BE COMPLETED BY THE HEALTH PROVIDER

Does the student have a past or present medical history of the following:

			REASON	DATE	PLACE
Allergies	Cancer	Hospitalizations			
Asthma	Orthopedic Problems	Surgery - What Kind?			
Congenital Heart Disease	Vision Problems	Serious Illness			
Convulsions	Hearing Problems	Serious Accidents			
Diabetes	Speech Problems	Other Problems/Limitations			

CHILD HISTORY

FAMILY HISTORY

PHYSICAL EXAMINATION: Height Weight Blood Pressure /

General Appearance (Nutritional Status)

NL	AB		NL	AB		NL	AB		NL	AB	
◯	◯	HEENT	◯	◯	Lungs	◯	◯	Extremities	◯	◯	Psych/Social
◯	◯	Dental Status	◯	◯	Cardiovascular	◯	◯	Back	◯	◯	Language
◯	◯	Neck	◯	◯	Abdomen	◯	◯	Skin	◯	◯	Behavioral
◯	◯	Lymph	◯	◯	GenitoUrinary	◯	◯	Neuro	◯	◯	Gross Motor
									◯	◯	Fine Motor

Describe Abnormalities:

SCREENING TESTS:

	DATE	RESULTS
Hematocrit/Hemoglobin	__/__/__	____ MM
HGB Electrophoresis	__/__/__	____ MM
Other Tests	__/__/__	____

HEARING:

	DATE	RESULTS	
Audio/Sweep	__/__/__	P	F
Threshold	__/__/__	P	F

VISION: DATE: __/__/__

FAR	P	F
NEAR	P	F
FUSION	P	F
COLOR	P	F

TB: For Intermediate/Middle School/Junior High School and High School

	DATE	RESULTS
Mantoux (PPD)Implanted	__/__/__	◯ Negative ____ MM
Read	__/__/__	◯ Positive ____ MM

FIRST TIME ENTRANTS

	Chest X-ray	BCG	On INH
DATE	__/__/__	__/__/__	__/__/__
RESULTS	◯ Normal ◯ Abnormal ◯ Not Indicated	◯ Yes ◯ No	◯ Yes ◯ No

LEAD:

	DATE	RESULTS	If at risk,	DATE	RESULTS
Do Risk Assessment	__/__/__	◯ No Risk ◯ At Risk	do venous screening	__/__/__	

IMMUNIZATION - DATES

DPT/DTaP or Dt or Td	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	Measles	__/__/__ __/__/__
POLIO: TOPV (Sabin)	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__		Mumps	__/__/__ __/__/__
IPV (Salk)	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__		Rubella	__/__/__ __/__/__
Hepatitis B	__/__/__	__/__/__	__/__/__				MMR	__/__/__ __/__/__
HIB	__/__/__	__/__/__					VZV	__/__/__ __/__/__

RECOMMENDATIONS FOR PHYSICAL ACTIVITY IN SCHOOL, ALSO IN EXTRACURRICULAR ACTIVITIES INCLUDING INTRAMURALS, INTERSCHOLASTIC COMPETITION AND WORKING PAPERS:

____ Full Physical activities including physical education, aerobics and contact sports.

____ **Student is also approved for working papers.**

____ Modified physical activity (Specify) _____

____ Specific physical activity contraindicated? _____

Special recommendations or modifications in pupil's program

Date of Examination:

MUST BE MECHANICALLY STAMPED

Physician's Name:
Address:
Name of Facility:
Telephone:

Physician's Signature