ST. JOSEPH'S COLLEGE OF NURSING
At St. Joseph's Hospital Health Center

STUDENT HEALTH RECORD

The New York State Department of Health and Education requires that each student submit a current physical exam (within one year), health history, and immunizations prior to participation in any health care program. This information is confidential and will be maintained in your Certified Profile account.

Name (print last name/first name):		
Address (including city/state/zip):		
Birth Date:		Phone Number:
Male / Female	Last 4 Digits of SSN#:	Are you an employee or volunteer at St. Joseph's? Yes / No
Health Care Provider:		Health Care Provider's Phone Number:

PLEASE ANSWER THE FOLLOWING:

1. Would you say your present health is: ❑ Excellent ❑ Good ❑ Fair ❑ Other
   If other, explain_____
2. Have you sustained an injury in the past six (6) months? ❑ No ❑ Yes
   If yes, explain_____
3. Have you ever been treated for back/neck pain or have any history of back/neck injury? ❑ No ❑ Yes
   If yes, explain_____
4. Any skin disorders, i.e. eczema, psoriasis, irritation or open lesions?
   ❑ No ❑ Yes, explain_____

ALLERGIES & EXPOSURES:

1. Do you have any allergies? ❑ No ❑ Yes, explain_____
   _____
2. Are you allergic to LATEX? ❑ No ❑ Yes

I understand that the Health Record will be treated as confidential and privileged. I give my permission to the College of Nursing at St. Joseph's Hospital to release my health forms to any affiliating organizations as necessary for clinical assignments **and employment**.

Signature_____Date_____