

Wellness Center

2500 North River Road | Manchester, NH 03106-1045 | Phone: 603.645.9616 | Fax: 603.645.9711 | www.snhu.edu

Medical Record

Date of university entry: _____

Program: ESL Undergraduate - Culinary Undergraduate Graduate BASHA BASIT CED Other
 Please check here if you are a Commuter Student

Please fill out this side prior to your doctor's visit. (Incomplete medical records will be returned)

I hereby certify that the information below is true and that I have read the attached Bill of Rights. I also give permission for this information contained within to be released to appropriate university personnel if necessary and to whatever insurance company may be processing claims on my behalf.

Signature of Student _____ Date

Name: _____ Date of Birth: _____
(month // date // year)

Home Address: _____
Street City State

_____ Zip Code Country Home Phone Cell Phone

Please notify in case of emergency:

Name: _____ Relationship: _____
 Address: _____ Business Phone: _____
 _____ Home Phone: _____

Consent for minor (if student is under 18 years of age): I give permission for my son/daughter to be treated for any accident or illness while a student at Southern New Hampshire University.

Parent/Guardian signature _____ Date

Medical History

Do you have or have you had:		Yes	No	Yes	No			
	Yes	No		Yes	No			
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Tropical Disease	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual problems	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>

If answer is "yes" to any of the above, please explain _____

Have you ever had any unusual or allergic reactions to medications, injections, etc? _____

List all medications you now take routinely _____

List any physical/emotional disabilities about which we should be alerted? _____

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Physician's Report (Mandatory for all international and resident students.)

To the Examiner: Please review the student's medical history (see other side) and complete this physical examination form. Comment on all positive findings and be sure all information is complete.

Name: _____ Gender: Male Female

BP: _____ Pulse: _____ Weight: _____ Height: _____

Immunization History Mandatory Immunizations (needed in order to register for classes)	Abnormalities																																							
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;"></td> <td style="text-align: center;">Date (month/day/year)</td> </tr> <tr> <td>Measles/Mumps/Rubella</td> <td>1st ____/____/____</td> </tr> <tr> <td></td> <td>2nd ____/____/____</td> </tr> </table>		Date (month/day/year)	Measles/Mumps/Rubella	1st ____/____/____		2nd ____/____/____	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 10%; text-align: center;">No</th> <th style="width: 10%; text-align: center;">Yes*</th> </tr> </thead> <tbody> <tr><td>Abdomen</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td></tr> <tr><td>Extremities/joints</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td></tr> <tr><td>Eyes, Head, Ears, Nose, Throat</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td></tr> <tr><td>Genitals</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td></tr> <tr><td>Heart</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td></tr> <tr><td>Hernia</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td></tr> <tr><td>Lungs</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td></tr> <tr><td>Mental Status</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td></tr> <tr><td>Neurological</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td></tr> <tr><td>Skin</td><td style="text-align: center;">_____</td><td style="text-align: center;">_____</td></tr> </tbody> </table>		No	Yes*	Abdomen	_____	_____	Extremities/joints	_____	_____	Eyes, Head, Ears, Nose, Throat	_____	_____	Genitals	_____	_____	Heart	_____	_____	Hernia	_____	_____	Lungs	_____	_____	Mental Status	_____	_____	Neurological	_____	_____	Skin	_____	_____
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<p>International Students Only — You must bring a written chest x-ray report (in English) with you in order to complete registration. The x-ray must have been taken in the two months prior to arriving at the university.</p>																																								
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Is the student under treatment for any medical or emotional conditions? Please explain: _____

Is the student physically qualified to participate in intercollegiate sports? Yes No If no, please explain: _____

List any other information about this student we should know to understand or treat this student: _____

Mail form to:
 Southern New Hampshire University | Wellness Center
 2500 North River Road | Manchester, N.H. 03106-1045
 Phone: 603.645.9616 | Fax: 603.645.9711

Physician's Signature: _____
 Print Physician's Name: _____
 Address: _____

 Phone: _____ Date: _____