Southern New Hampshire University

Personal Information

First name: _____ SNHU ID number: _____

Last name: _____ Preferred name: _____

Date of birth: _____ Phone: _____
MM/DD/YYYY

Program: ☐ Undergraduate ☐ Graduate

Emergency Contact

Name: _____ Relationship: _____

Phone 1: _____ ☐ Home ☐ Office ☐ Cell Phone 2: _____ ☐ Home ☐ Office ☐ Cell
Note: Include country and area code

Consent for Treatment of Minors *(required if applicant is under 18 years of age)*

I give permission for (Name)_____ to be treated for any accident or illness while at SNHU.

Parent or guardian's signature: _____ Date: _____

This packet must be filled out completely, signed by a doctor and submitted before the start of class. Students must upload this packet through the my.SNHU portal. Supplemental documents attached must be original and in English.

Requirements for students before arrival at SNHU:

- ☐ Physical exam within 6 months prior to the start of class (athletes only)
- ☐ Proof of vaccines or immunities
- ☐ TB Screening form and a TB test (if indicated) by the TB screening within 6 months prior to the start of classes
- ☐ Medical History form

Medical Record – Personal Health History

Check the appropriate boxes to indicate your personal medical history:

- ☐ ADD/ADHD
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Bipolar disorder
- ☐ Blood clots
- ☐ Breast disease
- ☐ Cancer
- ☐ Convulsions/seizure disorder
- ☐ Depression
- ☐ Diabetes
- ☐ Difficulty hearing
- ☐ Eating disorder
- ☐ Gallbladder disease
- ☐ Heart defect
- ☐ Heart disease
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Lung disease
- ☐ Mental health other
- ☐ Migraine headaches
- ☐ Mononucleosis
- ☐ Muscle/joint/bone problems
- ☐ Pneumonia
- ☐ Sickle cell disease or trait
- ☐ Skin diseases
- ☐ Stomach/intestinal problems
- ☐ Stroke
- ☐ Substance abuse
- ☐ Tobacco product use
- ☐ Tuberculosis
- ☐ Thyroid disease
- ☐ Vision problems
- ☐ Other (comment below)

If you checked any boxes, please explain (include treatment history):

Please list any serious illness, injuries or surgeries:

Do you take any medications regularly: ○ Yes ○ No If yes, please list drug(s) and dosage(s):

Please list any physical or emotional disability or impairment that you would like us to know about:

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Physical Exam (required for athletes only)

Must be completed 6 months prior to the start of classes.
Must be completed by a licensed medical provider/doctor.

First name: Middle name: Last name: SNHU ID number:

Date of birth: *MM/DD/YYYY* Date of exam:

Pulse: Blood pressure: Height: Weight:

Physical Exam Results

Head	◯ Normal	◯ Abnormal
Neck, thyroid	◯ Normal	◯ Abnormal
Eyes, ears, nose, throat, teeth	◯ Normal	◯ Abnormal
Hearing	◯ Normal	◯ Abnormal
Vision	◯ Normal	◯ Abnormal
Cardiovascular	◯ Normal	◯ Abnormal
Chest, lungs	◯ Normal	◯ Abnormal
Breasts	◯ Normal	◯ Abnormal
Abdomen	◯ Normal	◯ Abnormal
Genitourinary	◯ Normal	◯ Abnormal
Musculoskeletal	◯ Normal	◯ Abnormal
Skin	◯ Normal	◯ Abnormal
Neurological exam	◯ Normal	◯ Abnormal

Use this area to describe findings and recommendations:

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:

Medical provider signature: Print name: Date:

Address:

Phone number (including area code):

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Medical Record – Immunization Record

To be completed by a licensed medical provider/doctor.
Must be completed prior to arrival.

First name: Middle name: Last name: SNHU ID number:

Date of birth:
MM/DD/YYYY

Hepatitis B

You **MUST HAVE** one of the following three options:

☐ **1. Hepatitis B Vaccine** (dates given)

1st: 2nd:

3rd:

OR

☐ **2. Heplisav-B Vaccine given on or after 18 years of age** (dates given)

1st:

2nd:

OR

☐ **3. Immunity** (titer date and result)

Date:

Result:

Measles, Mumps and Rubella

You **MUST HAVE** one of the following three options:

☐ **1. MMR Vaccine**

Dates given

1st:

2nd:

OR

☐ **2. Measles Vaccine, Mumps Vaccine and Rubella Vaccine**

Measles vaccine dates given

1st: 2nd:

Mumps vaccine dates given

1st: 2nd:

Rubella vaccine dates given

1st: 2nd:

OR

☐ **3. Immunity to all 3 components**
(must submit laboratory result report)

Measles titer

Date: Result:

Mumps titer

Date: Result:

Rubella titer

Date: Result:

Meningococcal conjugate quadrivalent

Given between age 16-24 A, C, W, Y (ACWY-135, Menactra, Menveo or Nimenrix, MenQuadfi only)

Date given:

Tdap (tentanus, diphtheria, pertussis)

Booster within 10 years of enrollment date

Date given:

Varivax (chicken pox)

Vaccines containing varicella that are administered prior to 12 months will NOT be counted as part of the series. You **MUST HAVE** one of the following three options:

☐ **1. Vaccine dates given**

1st: 2nd:

OR

☐ **2. Date of disease**

OR

☐ **3. Immunity** (Varicella titer date and result)

Date: Result:

Medical provider signature: Print name: Date:

Address:

Phone number (including area code):

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Medical Record – Tuberculosis Screen

Must be completed prior to arrival. This may be completed in the **student portal**.

First name: Middle name: Last name: SNHU ID number:

Date of birth:
MM/DD/YYYY

Tuberculosis Screening Questions

1. Have you ever had close contact with persons known or suspected to have active TB disease? ○ Yes ○ No
2. Have you been a resident and/or employee in a high-risk setting? (e.g., correctional facilities, long-term care facilities and homeless shelters) ○ Yes ○ No
3. Have you been a volunteer or healthcare worker who served clients who are at risk for active TB disease? ○ Yes ○ No
4. Have you ever been a member of any of the following groups that may have increased incidence of latent M. tuberculosis infection or active TB disease: medically under-served, low-income or abusing drugs/alcohol? ○ Yes ○ No
5. Were you born in, or had frequent or prolonged visits to, one or more of the countries listed below? If yes, please **select the country(ies) below and select "Yes." If not, please select "No."** ○ Yes ○ No

List of Countries *(required if answering yes to question 5)*

- ☐ Afghanistan
- ☐ Algeria
- ☐ Angola
- ☐ Anguilla
- ☐ Argentina
- ☐ Armenia
- ☐ Azerbaijan
- ☐ Bangladesh
- ☐ Belarus
- ☐ Belize
- ☐ Benin
- ☐ Bhutan
- ☐ Bolivia (Plurinational State of)
- ☐ Bosnia and Herzegovina
- ☐ Botswana
- ☐ Brazil
- ☐ Brunei Darussalam
- ☐ Burkina Faso
- ☐ Burundi
- ☐ Cabo Verde
- ☐ Cambodia
- ☐ Cameroon
- ☐ Central African Republic
- ☐ Chad
- ☐ China
- ☐ China, Hong Kong SAR
- ☐ China, Macao SAR
- ☐ Colombia
- ☐ Comoros
- ☐ Congo
- ☐ Congo (Democratic Republic of)
- ☐ Cote d'Ivoire
- ☐ Djibouti
- ☐ Dominican Republic
- ☐ Ecuador
- ☐ El Salvador
- ☐ Equatorial Guinea
- ☐ Eritrea
- ☐ Eswatini
- ☐ Ethiopia
- ☐ Fiji
- ☐ Gabon

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Medical Record – Tuberculosis Screen

Must be completed prior to arrival. This may be completed in the **student portal**.

List of Countries Continued *(required if answering yes to question 5)*

- ☐ Gambia
- ☐ Georgia
- ☐ Ghana
- ☐ Greenland
- ☐ Guam
- ☐ Guatemala
- ☐ Guinea
- ☐ Guinea-Bissau
- ☐ Guyana
- ☐ Haiti
- ☐ Honduras
- ☐ India
- ☐ Indonesia
- ☐ Iraq
- ☐ Kazakhstan
- ☐ Kenya
- ☐ Kiribati
- ☐ Korea (Democratic People's Republic of)
- ☐ Korea (Republic of)
- ☐ Kyrgyzstan
- ☐ Lao People's Democratic Republic
- ☐ Lesotho
- ☐ Liberia
- ☐ Libya
- ☐ Lithuania
- ☐ Madagascar
- ☐ Malawi
- ☐ Malaysia
- ☐ Maldives
- ☐ Mali
- ☐ Marshall Islands
- ☐ Mauritania
- ☐ Mexico
- ☐ Micronesia (Federated States of)
- ☐ Moldova (Republic of)
- ☐ Mongolia
- ☐ Morocco
- ☐ Mozambique
- ☐ Myanmar
- ☐ Namibia
- ☐ Nauru
- ☐ Nepal
- ☐ Nicaragua
- ☐ Niger
- ☐ Nigeria
- ☐ Niue
- ☐ Northern Mariana Islands
- ☐ Pakistan
- ☐ Palau
- ☐ Panama
- ☐ Papua New Guinea
- ☐ Paraguay
- ☐ Peru
- ☐ Philippines
- ☐ Qatar
- ☐ Romania
- ☐ Russian Federation
- ☐ Rwanda
- ☐ Sao Tome and Principe
- ☐ Senegal
- ☐ Sierra Leone
- ☐ Singapore
- ☐ Solomon Islands
- ☐ Somalia
- ☐ South Africa
- ☐ South Sudan
- ☐ Sri Lanka
- ☐ Sudan
- ☐ Suriname
- ☐ Tajikistan
- ☐ Tanzania (United Republic of)
- ☐ Thailand
- ☐ Timor-Leste
- ☐ Togo
- ☐ Tunisia
- ☐ Turkmenistan
- ☐ Tuvalu
- ☐ Uganda
- ☐ Ukraine
- ☐ Uruguay
- ☐ Uzbekistan
- ☐ Vanuatu
- ☐ Venezuela (Bolivarian Republic of)
- ☐ Vietnam
- ☐ Yemen
- ☐ Zambia
- ☐ Zimbabwe

Source: WHO global lists of high burden countries for tuberculosis (TB), TB/HIV and multi drug/rifampicin-resistant TB (MDR/RR-TB), 2021–2025.

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Medical Record – Tuberculosis Test

To be completed by a licensed medical provider/doctor. Must be completed prior to arrival. **If you answered yes to any questions on the TB screen, you must submit a TB test report in English.**

First name: Middle name: Last name: SNHU ID number:

Date of birth:
MM/DD/YYYY

Medical provider to complete within 6 months prior to start of class. Please include TB test results for the test selected below.

Please check one of the following:

☐ 1. See attached laboratory report of tuberculosis screening blood test, Interferon Gamma Release Assay (IGRA). *(Must also submit a chest X-ray report if positive. Sputum cultures are NOT accepted.)*

Note: We do not interpret chest X-ray film

OR

☐ 2. See attached laboratory report of tuberculin skin test, Mantoux Method. *(Must also submit a chest X-ray report if positive.)*

OR

☐ 3. See attached report of chest X-ray. *(Report must be in English, X-ray films are not acceptable.)*

Medical provider signature: Print name: Date:

Address:

Phone number (including area code):