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 24 months prior to the start of class
- Proof of vaccines or immunities
- Completed Tuberculosis Test, if indicated by questionnaire, within 6 months prior to the start of class

MEDICAL RECORD FORM  Personal Health History

Place an “X” in 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:
Medical Record Form
Physical Exam
(To be completed by the DOCTOR)
MUST BE COMPLETED PRIOR TO ARRIVAL

Name:                                                                                         Date of Birth: 
                                    First                                         Middle                                         Last

Date of Exam:                                                                                     Gender:

Must be completed within the last 24 months

Pulse:      Blood Pressure:     Height:     Weight:

<table>
<thead>
<tr>
<th></th>
<th>Normal</th>
<th>Abnormal</th>
<th>Use this area to describe abnormal findings and recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neck, Thyroid</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes, Ears, Nose, Throat, Teeth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest, Lungs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breasts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitourinary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurological Exam</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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:

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Doctor Signature:                                                                                       Print Name: 

Address:                                                                                                  

Phone: (   )
# REQUIRED Immunizations

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Dates Given</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MMR Vaccine</strong></td>
<td>#1 <strong>/</strong>/  #2 <strong>/</strong>/</td>
</tr>
<tr>
<td>OR</td>
<td></td>
</tr>
<tr>
<td><strong>Measles Vaccine</strong></td>
<td>#1 <strong>/</strong>/  #2 <strong>/</strong>/</td>
</tr>
<tr>
<td><strong>Mumps Vaccine</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Rubella Vaccine</strong></td>
<td>#1 <strong>/</strong>/  #2 <strong>/</strong>/</td>
</tr>
</tbody>
</table>

**You must have** 2 doses of the MMR vaccine; or 2 doses of each component of the vaccine; or blood titers that show immunity to all (3) components.

**Vaccines containing measles/mumps/rubella that are administered before age 12 months will NOT be counted as part of the series.**

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Dates Given</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dtap or Td primary series</strong></td>
<td>#1 <strong>/</strong>/  #2 <strong>/</strong>/  #3 <strong>/</strong>/</td>
</tr>
<tr>
<td><strong>Tdap (tetanus, diphtheria, pertussis) booster within the past 10 years</strong></td>
<td><strong>/</strong>/</td>
</tr>
<tr>
<td><strong>Hepatitis B</strong></td>
<td>#1 <strong>/</strong>/  #2 <strong>/</strong>/  #3 <strong>/</strong>/</td>
</tr>
<tr>
<td>OR</td>
<td></td>
</tr>
<tr>
<td><strong>Blood Titer</strong></td>
<td></td>
</tr>
<tr>
<td><em>Hepatitis B Titer Date <strong>/</strong>/  Result ______</em></td>
<td></td>
</tr>
<tr>
<td><em>Must submit laboratory result report</em></td>
<td></td>
</tr>
<tr>
<td><strong>Meningococcal (quadrivalent)</strong></td>
<td>#1 <strong>/</strong>/  #2 <strong>/</strong>/</td>
</tr>
<tr>
<td><strong>Varivax (chicken pox)</strong></td>
<td>#1 <strong>/</strong>/  #2 <strong>/</strong>/</td>
</tr>
<tr>
<td><strong>Date of Disease</strong></td>
<td><strong>/</strong>/</td>
</tr>
</tbody>
</table>

**Vaccines containing varicella that are administered before age 12 months will NOT be counted as part of the series.**

---

**Doctor Signature:** ____________________________  **Date:** __________

**Print Name:** ____________________________  **Address:** ____________________________  **Phone:** __________
Medical Record Form

Tuberculous Screen

(To be completed by the DOCTOR)

MUST BE COMPLETED PRIOR TO ARRIVAL

Name: __________________________ Date of Birth: __________________________

If the answer is ‘YES’ to any of the below questions, SNHU requires that you receive Tuberculosis (TB) testing within 6 months prior to the arrival to the University.

Have you ever had close contact with persons known or suspected to have active TB disease?  □ Yes*  □ No

Are you born in one of the countries listed below that have a high incidence of active TB disease?  □ Yes*  □ No

(If yes, please CIRCLE the country below)

Afghanistan  Central African Republic  Ghana  Malawi
Algeria  Chad  Greenland  Malaysia
Angola  China  Guam  Maldives
Anguilla  China, Hong Kong SAR  Guatemala  Mali
Argentina  China, Macao SAR  Guinea  Marshall Islands
Armenia  Colombia  Guinea–Bissau  Mauritania
Azerbaijan  Comoros  Guyana  Mauritius
Bangladesh  Congo  Haiti  Mexico
Belarus  Côte d’Ivoire  Honduras  Micronesia (Federated States of)
Belize  Democratic People’s Republic of Korea  India  Mongolia
Benin  Democratic Republic of the Congo  Indonesia  Montenegro
Bhutan  Djibouti  Iraq  Morocco
Bolivia (Plurinational State of)  Dominican Republic  Israel  Mozambique
Bosnia and Herzegovina  Ecuador  Kenya  Myanmar
Botswana  El Salvador  Kiribati  Namibia
Brazil  Equatorial Guinea  Kuwait  Nauru
Brunei Darussalam  Eritrea  Kyrgyzstan  Nepal
Bulgaria  Ethiopia  Lao People’s Democratic Republic  Niger
Burkina Faso  Fiji  Latvia  Nigeria
Burundi  Gabon  Lesotho  Northern Mariana Islands
Cabo Verde  Gambia  Liberia  Pakistan
Cambodia  Georgia  Libya  Palau
Cameroon  Ghana  Lithuania  Panama
Central African Republic  Greenland  Macao SAR  Papau New Guinea
Chad  Guam  Philippines  Paraguay
China  Guatemala  Portugal  Peru
China, Hong Kong SAR  Guinea  Qatar  Philippines
China, Macao SAR  Guinea–Bissau  Republic of Korea  Portugal
Colombia  Guyana  Republic of Moldova  Qatar
Comoros  Haiti  Russian Federation  Rwanda
Congo  Honduras  Sao Tome and Principe  Sao Tome and Principe
Côte d’Ivoire  India  Senegal  Senegal
Democratic People’s Republic of Korea  Indonesia  Serbia  Serbia
Democratic Republic of the Congo  Iraq  Sierra Leone  Slovakia
Djibouti  Kazakhstan  South Africa  South Africa
Dominican Republic  Kenya  Sri Lanka  South Sudan
Ecuador  Kiribati  Sudan  Sudan
El Salvador  Kuwait  Suriname  Suriname
Equatorial Guinea  Kyrgyzstan  Swaziland  Syrian Arab Republic
Eritrea  Lao People’s Democratic Republic  Tajikistan  Tanzania (United Republic of)
Ethiopia  Latvia  Thailand  Timor–Leste
Gabon  Lesotho  Togo  Togo
Georgia  Liberia  Tuvalu  Tuvalu


Have you had frequent or prolonged visits* to one or more of the countries listed above with a high prevalence of TB disease?  □ Yes*  □ No (If yes, please CIRCLE the country above)

Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)?  □ Yes*  □ No

Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease?  □ Yes*  □ No

Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol?  □ Yes*  □ No
## Tuberculosis Test

(To be completed by the DOCTOR)

**MUST BE COMPLETED PRIOR TO ARRIVAL**

<table>
<thead>
<tr>
<th>Tuberculosis Test</th>
<th>Doctor to complete within 6 months prior to the start of class:</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>If you answered yes to any questions above you must submit a TB test report in English.</em></td>
<td>Either</td>
</tr>
<tr>
<td>□ 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.) Date <strong><strong>/</strong></strong>/_____ OR</td>
<td></td>
</tr>
<tr>
<td>□ 2. See attached laboratory report of Tuberculin Skin Test, Mantoux Method. (Must also submit a chest X-Ray report if positive.) OR</td>
<td></td>
</tr>
<tr>
<td>□ 3. See attached report of Chest X-Ray</td>
<td></td>
</tr>
</tbody>
</table>

**WE DO NOT INTERPRET CHEST X-RAY FILMS**

Doctor Signature: ____________________________ Date: ____________________________

Print Name: ____________________________

Address: ____________________________

Phone: ____________________________