Southern New Hampshire University

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
❑ Please check here if you are a Commuter Student

Please fill out this side prior to your doctor's visit.
I hereby certify that the information below is true and that I have received and read the attached Bill of Rights and have received and read the complaint procedure. I also give permission for the 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: _____ Personal E-mail Address: _____

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
Allergies	❑	❑	Epilepsy/Seizures	❑	❑	Menstrual problems	❑	❑
Mononucleosis	❑	❑	Tropical Disease	❑	❑	Ulcers	❑	❑
Asthma	❑	❑	Heart Disease	❑	❑	Urinary Problems	❑	❑
Psychiatric Care	❑	❑	Tuberculosis	❑	❑	Other	❑	❑
Diabetes	❑	❑	Hepatitis	❑	❑			
Rheumatic Fever	❑	❑	High Blood Pressure	❑	❑	_____		

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 (include all medications) _____

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.). Physical exam must be completed within 12 months prior to arriving at the University.

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: _____ Date of Exam: _____ Gender: Male ❑ Female ❑ Transgender ❑ Other ❑

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

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 six months prior to arriving at the university.

Immunization History

Mandatory Immunizations (needed in order to register for classes)

	Date (month/day/year)
Measles/Mumps/Rubella	1st _____/_____/_____
	2nd _____/_____/_____

Recommended Immunizations

	Date (month/day/year)
Tetanus (within 10 years)	_____/_____/_____
Hepatitis B	1st _____/_____/_____
	2nd _____/_____/_____
	3rd _____/_____/_____
Meningococcal	1st _____/_____/_____
	2nd _____/_____/_____
PPD Test (within 12 months)	_____/_____/_____
(for students living in high risk areas)	
Results:	_____ _____
Varivax (chicken pox vaccine)	1st _____/_____/_____
	2nd _____/_____/_____
OR Date of disease:	_____/_____/_____

Physical Exam

	Abnormal*	Normal
Abdomen	❑	❑
Communicable Disease	❑	❑
Extremities/joints	❑	❑
Eyes, Head, Ears, Nose, Throat	❑	❑
Genitals	❑	❑
Heart	❑	❑
Hernia	❑	❑
Lungs**	❑	❑
Mental Status	❑	❑
Neurological	❑	❑
Skin	❑	❑

***Chest x-ray required for International Students*

* If abnormal, please explain:

_____

_____

_____

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: _____ Date: _____
Print Physician's Name: _____
Address: _____
_____
Phone: _____