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

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.)

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 ☐ Transgender ☐ Other ☐

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

Immunization History

Mandatory Immunizations (needed in order to register for classes)

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

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.

Recommended Immunizations

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

Abnormalities

	No	Yes*
Abdomen	_____	_____
Communicable Disease	_____	_____
Extremities/joints	_____	_____
Eyes, Head, Ears, Nose, Throat	_____	_____
Genitals	_____	_____
Heart	_____	_____
Hernia	_____	_____
Lungs	_____	_____
Mental Status	_____	_____
Neurological	_____	_____
Skin	_____	_____

* If yes, 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: _____
Print Physician's Name: _____
Address: _____

_____

Phone: _____ Date: _____