

# MANCHESTER COMMUNITY COLLEGE

1066 Front Street, Manchester, NH 03102 P: (603) 206-8020 F: (603) 206-8298  
www.mccnh.edu

## Health Questionnaire / Physical Exam Form

(Please type or use a black ball point pen)

Program \_\_\_\_\_

This information will be used as an aid in providing necessary health care while you are a student. Information supplied will become part of your health record, and will not influence your standing at the college.

### 1. General Information

Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Last 4 digits of Soc Sec No: \_\_\_\_\_

### 2. Emergency Notification

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_

### 3. Please list all health insurance coverage.

(Note: Students in health care programs or sports are required to provide proof of health insurance coverage.)

Company: \_\_\_\_\_ Policy No: \_\_\_\_\_

Name of Policyholder(s): \_\_\_\_\_

#### For Student:

I hereby grant permission to an authorized representative of the College to secure such medical care as I, \_\_\_\_\_, may require including examination, treatment, and immunization. This permission is with the understanding that, in the event of serious illness, the College will use all reasonable efforts to contact the person identified in Section 2.

#### For Parent or Guardian of Student under the age of 18 years:

I hereby grant permission to an authorized representative of the College to secure such medical care as is required including examination, treatment, and immunization. This permission is with the understanding that, in the event of serious illness, the College will use all reasonable efforts to contact me.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

4. Please indicate any history of the following conditions. Explain "yes" answers in space provided or attach an extra sheet if necessary.

	YES	NO
Alcohol or Drug Abuse		
Allergies (Food/Medicine)		
Arthritis		
Asthma ( <i>state frequency &amp; the date of last attack</i> )		
Back Problems		
Bleeding Abnormality		
Cancer		
Concussion (head injury)		
Convulsions/Seizures		
Dental Problems		
Diabetes or Hypoglycemia ( <i>please explain treatment</i> )		
Eating Disorder		
Eye Disease		
Headaches		

	YES	NO
Heart Disease		
Hepatitis		
Hernia		
High Blood Pressure		
Intestinal Problems		
Kidney Disease, Urinary Infections		
Mononucleosis		
Psychiatric or Emotional Problems		
Rheumatic Fever		
Stomach or Gallbladder Problems		
Thyroid Problems		
Tuberculosis		
Venereal Disease		
Other Problems		

Explanation: \_\_\_\_\_

5. Please list any previous illnesses or operations requiring hospitalization and date(s): \_\_\_\_\_

6. Please list any previous fractures (*broken bones*) and date(s): \_\_\_\_\_

7. Please list any physical disabilities or handicaps: \_\_\_\_\_

8. Please list any medications or desensitization shots taken frequently or regularly: \_\_\_\_\_

9. If you are under a physician's continuing care for any reason, a summary from your physician concerning your treatment and medications should be submitted to the **Vice President of Student and Community Development**.

10. Immunizations (To be completed and signed by Physician or Registered Nurse (RN) for ALL Students):

	Date of Vaccination or Titer	Titer Results
Polio		
Tetanus (within last 10 years)		
Mumps		
Measles (must have either shot or titer)		
Rubella (must have either shot or titer)		
Tuberculin Skin Test (within past year – positive test requires Chest X-Ray)		
Hepatitis B Series (check program requirements)		

Signature: \_\_\_\_\_ MD / RN

11. To be completed by Physician for students in **CHILD CARE**, and for students participating in **ATHLETICS**:

Height \_\_\_\_\_ Weight \_\_\_\_\_ Ears \_\_\_\_\_  
 Hearing Right : \_\_\_\_\_ Left: \_\_\_\_\_ Eyes \_\_\_\_\_ Glasses or Contacts \_\_\_\_\_  
 Nose \_\_\_\_\_ Throat & Mouth \_\_\_\_\_ Skin \_\_\_\_\_  
 Speech \_\_\_\_\_ Heart \_\_\_\_\_ Thyroid \_\_\_\_\_  
 Abdomen \_\_\_\_\_  
 Genitalia \_\_\_\_\_ Lungs \_\_\_\_\_  
 Orthopedic: Spine \_\_\_\_\_ Feet \_\_\_\_\_ Joints \_\_\_\_\_ Extremities \_\_\_\_\_  
 Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_

**Any History of:** (please give date)

Alcohol or Drug Abuse: \_\_\_\_\_ Heart Disease: \_\_\_\_\_ Asthma: \_\_\_\_\_  
 Epilepsy: \_\_\_\_\_ Diabetes: \_\_\_\_\_  
 TB or contact with TB: \_\_\_\_\_ Psychiatric or Emotional Problems: \_\_\_\_\_

**Other:**

If yes to any of the above, please explain: \_\_\_\_\_  
 \_\_\_\_\_

What medication, if any, does the student take regularly? \_\_\_\_\_  
 \_\_\_\_\_

Please list any previous illnesses or operations requiring hospitalization and date(s): \_\_\_\_\_

May the student participate in all normal college activities including intercollegiate sports? \_\_\_\_\_

If no, what is the disability? \_\_\_\_\_

What are the restrictions? \_\_\_\_\_

How long? \_\_\_\_\_ Permanent \_\_\_\_\_ One Semester \_\_\_\_\_

Has the applicant ever had a heart murmur, Rheumatic Fever, or any other condition that would require pre-medication before dental treatment? \_\_\_\_\_

**SIGNATURE OF PHYSICIAN** \_\_\_\_\_ **DATE** \_\_\_\_\_

Physician Name (*please type*): \_\_\_\_\_

Facility \_\_\_\_\_ Address: \_\_\_\_\_

Upon completion, please forward to:

**Manchester Community College  
Office of Admissions  
1066 Front Street  
Manchester, NH 03102-8518**

If you have any questions please contact the Office of Admissions by:

Phone: (603) 206-8100

Fax: (603) 206-8275

Email: [ManchesterAdmissions@ccsnh.edu](mailto:ManchesterAdmissions@ccsnh.edu)

Online: [www.mccnh.edu/admissions](http://www.mccnh.edu/admissions)