

MANCHESTER COMMUNITY COLLEGE

Health Questionnaire / Physical Exam

(Please type or use a black ball point pen)

PROGRAM _____

No. 1 – 9 are required to be completed by ALL students
 No. 10 is to be completed by a physician or RN (for ALL students)
 No. 11 is to be completed by a physician or RN (for specified students)

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. 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		YES	NO
Alcohol or Drug Abuse			Hepatitis		
Allergies (Food/Medicine)			Hernia		
Arthritis			High Blood Pressure		
Asthma (state frequency & the date of last attack)			Intestinal Problems		
Back Problems			Kidney Disease, Urinary Infections		
Bleeding Abnormality			Headaches		
Cancer			Mononucleosis		
Concussion (head injury)			Psychiatric or Emotional Problems		
Convulsions/Seizures			Rheumatic Fever		
Dental Problems			Stomach or Gallbladder Problems		
Diabetes or Hypoglycemia (please explain treatment)			Thyroid Problems		
Ear Trouble/Hearing Loss			Tuberculosis		
Epilepsy (please explain treatment)			Venereal Disease		
Eating Disorder			Heart Disease		
Eye 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 Dean of Students.**

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 ALLIED HEALTH, NURSING, 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 _____

Lab Work – Please forward reports to MCC:

CBC (complete blood count) _____ Urinalysis _____

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

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 Phone: (603) 668-6706
 Fax: (603) 668-5354
 TTY: (603) 668-1792