



Name: \_\_\_\_\_  
Last First

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Preferred Name: \_\_\_\_\_

Contact Number: \_\_\_\_\_ SNHU ID Number: \_\_\_\_\_

Program:  UG  G  ESL

**PERSON TO NOTIFY IN CASE OF EMERGENCY (INCLUDE COUNTRY AND AREA CODE):**

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

Phone 1: \_\_\_\_\_  Home  Office  Cell Phone 2: \_\_\_\_\_  Home  Office  Cell

Consent for treatment of minors: I give permission for my son/daughter to be treated for any accident or illness while at SNHU:

Parent or Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Required if applicant is under 18 years of age)

**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

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> ADD/ADHD                     | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Liver Disease                | <input type="checkbox"/> Stomach/Intestinal Problems |
| <input type="checkbox"/> Anemia                       | <input type="checkbox"/> Difficulty Hearing  | <input type="checkbox"/> Lung Disease                 | <input type="checkbox"/> Stroke                      |
| <input type="checkbox"/> Anxiety                      | <input type="checkbox"/> Eating Disorder     | <input type="checkbox"/> Mental Health Other          | <input type="checkbox"/> Substance Abuse             |
| <input type="checkbox"/> Asthma                       | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Migraine Headaches           | <input type="checkbox"/> Tobacco Product Use         |
| <input type="checkbox"/> Bipolar Disorder             | <input type="checkbox"/> Heart Defect        | <input type="checkbox"/> Mononucleosis                | <input type="checkbox"/> Tuberculosis                |
| <input type="checkbox"/> Blood Clots                  | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Muscle/Joint/Bone Problems   | <input type="checkbox"/> Thyroid Disease             |
| <input type="checkbox"/> Breast Disease               | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Pneumonia                    | <input type="checkbox"/> Vision Problems             |
| <input type="checkbox"/> Cancer                       | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sickle Cell Disease or Trait | <input type="checkbox"/> Other (Comment Below)       |
| <input type="checkbox"/> Convulsions/Seizure Disorder | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Skin Diseases                | _____  |
| <input type="checkbox"/> Depression                   | <input type="checkbox"/> Kidney Disease      |   | _____  |

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: \_\_\_\_\_

	Normal	Abnormal	Use this area to describe abnormal findings and recommendations
Head			
Neck, Thyroid			
Eyes, Ears, Nose, Throat, Teeth			
Hearing			
Vision			
Cardiovascular			
Chest, Lungs			
Breasts			
Abdomen			
Genitourinary			
Musculoskeletal			
Skin			
Neurological Exam			

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: (       ) \_\_\_\_\_

# Medical Record Form

## Section Three: Immunization Record

(To be completed by the DOCTOR)

MUST BE COMPLETED PRIOR TO ARRIVAL

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

REQUIRED Immunizations	Dates Given	
MMR Vaccine	#1 ___/___/___ #2 ___/___/___	<p><b>Vaccines containing measles/mumps/rubella that are administered before age 12 months will NOT be counted as part of the series.</b></p>
OR	OR	
Measles Vaccine	#1 ___/___/___ #2 ___/___/___	
AND Mumps Vaccine	#1 ___/___/___ #2 ___/___/___	
AND Rubella Vaccine	#1 ___/___/___ #2 ___/___/___	
<p>You <b>must have</b> 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.</p>	<p>OR</p> <p>*Measles Titer Date ___/___/___ Result _____</p> <p>*Mumps Titer Date ___/___/___ Result _____</p> <p>*Rubella Titer Date ___/___/___ Result _____</p> <p><i>*Must submit laboratory result report</i></p>	
Dtap or Td primary series	#1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___ #5 ___/___/___	
Tdap (tetanus, diphtheria, pertussis) booster within the past 10 years	___/___/___	
Hepatitis B OR Blood Titer	#1 ___/___/___ #2 ___/___/___ #3 ___/___/___ OR *Hepatitis B Titer Date ___/___/___ Result _____ <i>*Must submit laboratory result report</i>	
Meningococcal (quadrivalent)	#1 ___/___/___ #2 ___/___/___	
Varivax (chicken pox) OR Date of Disease:	#1 ___/___/___ #2 ___/___/___ OR ___/___/___	<p><b>Vaccines containing varicella that are administered before age 12 months will NOT be counted as part of the series.</b></p>

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

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

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2015. Countries with incidence rates of  $\geq 20$  cases per 100,000 population. For future updates, refer to <http://www.who.int/tb/country/en/>.

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

## Medical Record Form

### Tuberculous Test

(To be completed by the DOCTOR)

MUST BE COMPLETED PRIOR TO ARRIVAL

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

Tuberculosis Test	Doctor to complete within 6 months prior to the start of class:
<p>*If you answered yes to any questions above you must submit a TB test report in English.</p> <p>*If your TB Test is positive, you must submit a chest X-Ray report in English.</p> <p><b>WE DO NOT INTERPRET CHEST X-RAY FILMS</b></p>	<p style="text-align: center;">Either</p> <p><input type="checkbox"/> 1. See attached laboratory report of Tuberculosis screening blood test, Interferon Gamma Release Assay (IGRA). (Must also submit a chest X-Ray report if postive.)</p> <p>Date ____/____/____</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> 2. See attached laboratory report of Tuberculin Skin Test, Mantoux Method. (Must also submit a chest X-Ray report if postive.)</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> 3. See attached report of Chest X-Ray</p> <p><b>Doctor Signature:</b> _____ <b>Date:</b> _____</p> <p><b>Print Name:</b> _____</p> <p><b>Address:</b> _____</p> <p><b>Phone:</b> _____</p>