Southern New Hampshire University

Name: _____
Last *First*

Date of Birth: ___/___/___ (*MM DD YYYY*) 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 (Name)_____ 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

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

_____

_____

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: _____

_____

Southern New Hampshire University

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: ( ) _____

Southern New Hampshire University

Medical Record Form

Immunization Record

(To be completed by the DOCTOR)

MUST BE COMPLETED PRIOR TO ARRIVAL

Name: Date of Birth:

REQUIRED Immunizations	Dates Given
MMR Vaccine OR Measles Vaccine AND Mumps Vaccine AND Rubella Vaccine You **must have** 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.	#1 ___/___/___ #2 ___/___/___ OR #1 ___/___/___ #2 ___/___/___ #1 ___/___/___ #2 ___/___/___ #1 ___/___/___ #2 ___/___/___ OR *Measles Titer Date ___/___/___ Result _____ *Mumps Titer Date ___/___/___ Result _____ *Rubella Titer Date ___/___/___ Result _____ **Must submit laboratory result report*
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 _____ **Must submit laboratory result report*
Meningococcal (quadrivalent)	#1 ___/___/___ #2 ___/___/___
Varivax (chicken pox) OR Date of Disease:	#1 ___/___/___ #2 ___/___/___ OR ___/___/___

Vaccines containing measles/mumps/rubella that are administered before age 12 months will NOT be counted as part of the series.

Vaccines containing varicella that are administered before age 12 months will NOT be counted as part of the series.

Doctor Signature: Date:

Print Name: Address: Phone:

Southern New Hampshire University

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

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2015. Countries with incidence rates of ≥ 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

Southern New Hampshire University

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:
*If you answered yes to any questions above you must submit a TB test report in English. *If your TB Test is positive, you must submit a chest X-Ray report in English. **WE DO NOT INTERPRET CHEST X-RAY FILMS**	Either ☐ 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.) Date _____/_____/_____ OR ☐ 2. See attached laboratory report of Tuberculin Skin Test, Mantoux Method. (Must also submit a chest X-Ray report if postive.) OR ☐ 3. See attached report of Chest X-Ray **Doctor Signature:** _____ Date: _____ **Print Name:** _____ **Address:** _____ **Phone:** _____