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

for Students in the Allied Health Programs

(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: _____ Cell Phone:_____

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 *(state frequency & the date of last attack)*		
Back Problems		
Bleeding Abnormality		
Cancer		
Concussion (head injury)		
Convulsions/Seizures		
Dental Problems		
Diabetes or Hypoglycemia *(please explain treatment)*		
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. 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 _____

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? _____

MMR:

Date of 2 vaccines or MMR titer (laboratory evidence of immunity)

MMR #1: **or MMR Titer results:** Measles: Date _____ Result:_____

MMR #2: Mumps: Date _____ Result:_____

Rubella: Date _____ Result:_____

Tetanus (Td: within 10 years) **or** **Tetanus, diphtheria and attenuates pertussis (Tdap)**

Date: _____ Date: _____

Tuberculin Skin Test (Mantoux 5TU PPD)

Initial two step testing required for all Nursing students before the start of classes, then one TB test annually.

Date given: _____ Date Read: _____ Result _____

Date given: _____ Date Read: _____ Result:_____

Chest Xray (required if tuberculin test is positive) Date: _____ Result:_____

Hepatitis B Vaccine (Dates of 3 vaccine series or signed waiver):

#1: _____

#2: _____

#3: _____

Varicella (Chicken Pox):

Dates of 2 vaccines or date and results of titer. History of disease is not sufficient.

#1: _____ or Varicella Titer: Date_____ Results:_____

#2: _____

Copies of medical records, all immunizations and test results can be used in lieu of this form

SIGNATURE OF PHYSICIAN _____ **DATE**_____

Physician Name *(please type)*: _____

Facility _____ Address: _____

Upon completion, please forward to:

Manchester Community College
Allied Health/Nursing Departments
1066 Front Street
Manchester, NH 03102-8518

If you have any questions please contact the Allied Health/Nursing Departments by:
Phone: (603) 206-8020
Fax: (603) 206-8298
Online: www.mccnh.edu