Nashua Community College

HEALTH QUESTIONNAIRE

All students are required to complete Health Questionnaire in full.

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. Program: _____

1. Name in Full _____ Social Sec# _____

   Home Address _____ Date of Birth: _____

   _____ Telephone: _____

2. **Emergency Notification:**

   Name _____ Home Telephone # _____

   Relationship _____ Business Telephone # _____

   Home Address _____

3. Please list all health insurance coverage. **Note:** Students participating in **athletics** are required to provide proof of health insurance coverage.

   Company _____ Policy Number _____

   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.
NAME OF STUDENT
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 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 effort 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 & 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

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

_____

_____

6. Please list any previous fractures (broken bones) and date:

_____

_____

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 Student Services Office.

10.

TO BE COMPLETED BY PHYSICIAN OR RN FOR ALL STUDENTS
Immunizations – must be completed and signed by physician or registered nurse.

Physician / RN – Please Note:
New Immunization regulations require that documentation of 2 doses of measles containing vaccine with the 1st dose being administered at 12 months or older and at least 30 days between the 1st and 2nd dose.

Does this student comply with this new regulation? Yes _____ No _____

	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)	_____	Results _____

Signature: _____ MD/RN