HEALTH SERVICES
TEL (603) 641-7028
FAX (603) 641-7318

SAINT ANSELM COLLEGE

ADMISSION HEALTH REPORT FORM

Please answer all questions & keep a copy of these pages for your record

This information is strictly **CONFIDENTIAL** and will be used as an aid to provide necessary health care while you are a student. Information supplied will become a part of your health record, will not influence your standing at the College, and will not be released to anyone except by your written authorization.

RETURN COMPLETED FORM TO:

HEALTH SERVICES, SAINT ANSELM COLLEGE, 100 SAINT ANSELM DRIVE, MANCHESTER, NH 03102-1310

NAME_____DOB _____
Last / First / Middle Initial

Home Address _____
Street City / State / Zip

Student's Cell # _____ Home Tel# _____

PARENTS' NAMES or Legal Guardian (LG): _____

Mom's work #_____ Dad's work #_____ LG(Wk#) _____

Mom's cell # _____ Dad's cell # _____ LG(Cell#) _____

Emergency Notification if different from above _____
Name / Relationship / Phone #

International Students – Emergency Contact in the USA: _____

CLASS: ❒Fr. ❒So. ❒Jr. ❒Sr. ❒Other SEX: ❒M ❒F MARITAL STATUS: _____ CITIZEN USA: ❒Yes or _____ (Name Other)
To live on campus _____ or commuter_____

Do you plan to try out for a varsity sport? Yes or No _____ List sport(s): _____

Note physical exam requirements: NCAA mandates a sport's history and physical on any athlete within 6 months from date of 1st sport tryout.

Permission is granted to release information to the Athletic Training Department if I participate in a varsity sport. _____
Signature of Student (if under 18, Parent of Student)

Your (student's) PAST OR PRESENT HISTORY OF: (Circle if any issues have pertained to YOU and explain below)

ADD/ADHD	Depression	Hepatitis	Schizophrenia
Anemia	Diabetes	HIV Infections/AIDS	Seizures
Anxiety	Dizziness / Fainting / Blackouts	Intestinal Problems	Sexually Transmitted Diseases
Asperger's Disorder/Autism/PDD	Drug or Alcohol Issues	Joint Disease	Sickle Cell Disease / Trait
Asthma / Lung Disorders	Eating Disorder	Kidney Disease	Skin Disorders
Bi-polar Disorder	Emotional Problems	Learning Disability	Sleep Issues
Bleeding abnormal	Epilepsy / Convulsions	Leukemia	Staphylococcal Infection / MRSA
Cancer & / Impaired Immunity	Head Injury / Concussion	Migraine Headaches	Stomach Problems
Chicken Pox	Hearing Loss	Missing Organs	Thyroid Disorder
Contact Lenses	Heart Disease or Murmurs	Mononucleosis	Weight Issues
COVID-19	Heat Stroke/Exhaustion	Orthopaedic Injuries	NONE OF THE ABOVE

EXPLAIN ALL / & or OTHER: _____

CURRENT MEDICATION by prescription or over the counter (List includes birth control pills, herbal and sport related supplements):

ALLERGIES TO:	Will you need allergy desensitization therapy? Yes or No If yes, **bring serum and signed schedule from your home physician**	**Should you have an epi-pen for use if necessary?** Yes or No Do you have one? Yes or No

COVID-19 Vaccinated? YES NO

TUBERCULOSIS SCREENING QUESTIONNAIRE RISK FACTOR:

Have you ever had a positive tuberculin skin test in the past? YES❒ NO ❒	Were you born outside the US?
Have you had close contact w/anyone who was sick? YES❒ NO ❒	Have you ever spent significant time in a country outside of the US? YES ❒ NO ❒ Country:

Sleep _____hours a night

Current Weight: _____ lbs. Ideal Weight as You would like to be _____lbs. Hospitalizations: _____

Dietary needs: _____ Surgeries: _____

Menstrual Cycle: Frequency _____ Duration_____ Problems_____

Have you ever lost your Period for a prolonged period of time? ____ Please explain:_____

Have you received mental health services? In-patient: Yes or No or Out-patient: Yes or No

Please explain:_____

Name _____ Sport _____

FAMILY HISTORY: Circle if ANY OF YOUR BLOOD RELATIVES HAVE or HAD - grandparents, parents, siblings, and blood aunt(s) and uncle(s) -

	RELATION		RELATION
Allergies	_____	Epilepsy/Convulsions	_____
Alcoholism/Drug Abuse	_____	Familial Disease	_____
Asthma	_____	Heart Disease	_____
Autism	_____	Intestinal Problems	_____
Bleeding, abnormal	_____	Kidney Disease	_____
Bi-polar disease	_____	Lung Disease/TB	_____
Bone disorders / osteoporosis	_____	Migraine Headache	_____
Cancer and/or impaired immunity	_____	Stomach Problems	_____
Depression / Suicide	_____	Schizophrenia	_____
Diabetes	_____	Please indicate if you are adopted	_____

Or None of the Above_____

Any family member died before the age of 55, list with cause of death _____

_____

FAMILY HISTORY	AGE	STATE OF HEALTH	CAUSE OF DEATH (if applicable)	AGE AT DEATH	FAMILY HISTORY	AGE	STATE OF HEALTH	CAUSE OF DEATH (if applicable)	AGE
Father					Sibling				
Mother					Sibling				
Sibling					Sibling				
Sibling					Sibling				

Primary Care Physician _____

Name Address State Zip

_____ _____

Office Tel.# Fax Tel.#

INSURANCE INFORMATION: (PLEASE STAPLE *COPY* OF BOTH SIDES OF INSURANCE CARD TO THIS FORM)

NAME OF INSURANCE: _____ **HMO:** ❒Yes ❒No **PPO:** ❒Yes ❒No

SUBSCRIBER'S NAME _____ INS. TELE # _____

SUBSCRIBER'S DOB_____ EFFECTIVE DATE OF POLICY_____

POLICY NO.:_____ GROUP NO.: _____

I hereby authorize Saint Anselm College Health Services and the Athletic Training Department to provide routine examinations, diagnosis and treatment. I acknowledge that Saint Anselm College contracts with and makes referrals to outside independent laboratories/health care providers which will be billed to the student's medical insurance. I agree to release Saint Anselm College, its professional health care providers and employees from any and all liability arising from any such referrals or contracted services. I understand that Saint Anselm College complies with NH State Public Health regulations and is required to report certain positive lab results to public health agencies. In the event that a I am referred to an outside provider I authorize that provider to provide Saint Anselm College Athletic Training and Health Services copies of my office notes.

In the event of an emergency, I hereby give my permission to be treated and transported to the closest emergency facility for appropriate medical treatment. I give permission for Saint Anselm personnel to release pertinent medical/insurance information to that emergency facility and if necessary to notify my emergency contact listed above.

I hereby certify the information on this form is complete to the best of my knowledge. Withholding or falsifying information can result in immediate loss of playing status, or other sanctions deemed by the Department of Athletics, if applicable.

I have read, understand, and agree with the Saint Anselm College Health Services Philosophy and Mission Statement.
I have read and received a copy of the Residential Care and Health Facility Licensing Patients Bill of Rights (see Admissions Portal or Health Services Webpage/freshman forms).

Signature of Student_____ Date_____

And/or _____ Date_____

Parent or Guardian if student is under 18 years