

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, (#1722) 100 SAINT ANSELM DRIVE, MANCHESTER, NH 03102-1310

NAME Last / First / Middle Initial DOB

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 RN/BSN 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.

Signat

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

EXPLAIN ALL / & or OTHER:

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

Table with 3 columns: ALLERGIES TO, Will you need allergy desensitization therapy? Yes or No, Should you have an epi-pen for use if necessary? Yes or No. Do you have one? Yes or No

TUBERCULOSIS SCREENING QUESTIONNAIRE RISK FACTOR:

Table with 2 columns: Tuberculosis screening questions regarding skin tests, contact with sick individuals, and time spent in foreign countries.

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) -

	<b>RELATION</b>		<b>RELATION</b>
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 and /or medical records.

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 Parent or Guardian if student is under 18 years \_\_\_\_\_ Date \_\_\_\_\_

