



# Center for Health and Wellness

Promoting Health and Wellness that Facilitates a World of Possibilities

Keene State College  
 229 Main Street  
 Keene, NH 03435-2802  
 603-358-2450  
 603-358-2444 fax  
 www.keene.edu/chw

## Comprehensive Student Health and Disability Report

### Part I: General Information

All information disclosed on this form will be kept confidential and will be shared with appropriate College personnel on a need-to-know basis only. Please return your completed report to Health Services, using the enclosed return envelope.

Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
 Last First Middle Maiden

Home Address \_\_\_\_\_ Home Tel. No. \_\_\_\_\_  
 No./Street/Apt. City State Zip

Marital Status \_\_\_\_\_ Children? \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_

Veteran  N  Y Branch \_\_\_\_\_ Yrs. of Service \_\_\_\_\_ Sex  F  M

Transfer Student?  Y  N Previous College \_\_\_\_\_ Citizenship \_\_\_\_\_

Place of Birth \_\_\_\_\_

### Emergency Contacts

**Primary:** Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home \_\_\_\_\_ Office \_\_\_\_\_ Cell \_\_\_\_\_

**Secondary:** Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home \_\_\_\_\_ Office \_\_\_\_\_ Cell \_\_\_\_\_

Health Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_ Policy Holder \_\_\_\_\_

### Family History

Are you adopted?  yes  no

Name	Occupation	Year of birth	State of health	Age of death	Cause of death
Father					
Stepfather					
Mother					
Stepmother					
Sibling					
Sibling					
Sibling					



## Comprehensive Student Health and Disability Report

### Family History

Have your blood relatives had any of the following?

	Y	N	Relationship		Y	N	Relationship
Alcoholism/drug abuse				Emotional problems			
Allergies				Headaches			
Arthritis				Heart disease			
Asthma				High blood pressure			
Cancer				Kidney disease			
Cholesterol problem				Intestinal problems			
Depression				Learning disabilities			
Diabetes				Lung disease/TB			
Epilepsy/convulsions				Stomach disease			
				Stroke			

### Part II: Medical History

*This form (all pages) must be completed by the student.*

All information disclosed on this form will be kept confidential and will be shared with appropriate College personnel on a need-to-know basis only. Please return your completed report to Health Services, using the enclosed return envelope.

1. Describe any ongoing health problems or conditions requiring medical care. \_\_\_\_\_

**Have you ever had any of the following:**

2. Adverse or allergic reaction to any medication
3. Allergic reaction to food, insect bites, or other
4. Mumps
5. Mononucleosis (Mono)
6. German measles (Rubella)
7. Hard measles (Rubeola)
8. Chicken pox
9. Tuberculosis
10. Operation or serious injury
11. Hospitalization
12. X-ray therapy to the head or neck
13. List any medications you use:

**Yes No**

- |                          |                          |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

**Details: Identify question by number, include diagnosis, age or dates, and treatment.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Have you ever had or been treated for any of the following:**

14. Serious disease of eye, ears, nose, or throat
15. Frequent or severe headaches or convulsions, or a severe head injury
16. Lung disease, asthma, persistent cough, or shortness of breath
17. High blood pressure, rheumatic fever, heart murmur, heart attack, or other disorder of heart or blood vessels
18. Frequent or severe abdominal pain, hepatitis, problems with bowel movements, rectal bleeding, or other intestinal problem
19. Sugar, protein, or blood in urine, or bladder or kidney problem

- |                          |                          |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



## Comprehensive Student Health and Disability Report

---

### Medical History continued

- |   | Yes                      | No                       |       |
|---|--------------------------|--------------------------|-------|
| 20. A sexually transmitted infection (STI)  | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 21. Diabetes, thyroid, or other endocrine disorder  | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 22. Anemia or other disorder of the blood   | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 23. Bone, joint, or muscle problem; back pain; arthritis; physical deformity or paralysis | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 24. Hay fever, hives, or other allergy  | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 25. Severe acne, eczema, or other skin disorder   | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 26. Cancer or other tumor   | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 27. A disorder not listed above (specify)   | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

#### Do you...

- |   |                          |                          |       |
|---|--------------------------|--------------------------|-------|
| 28. Know your blood type? Type:   | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 29. Smoke or chew tobacco? Amount:  | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 30. Have a special diet? (Explain)  | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 31. Drink alcoholic beverages? (Specify type and number of drinks per week) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 32. Use recreational drugs? (Please specify)                                | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

#### Women Only

- |   |                          |                          |       |
|---|--------------------------|--------------------------|-------|
| 33. Have you ever had a menstrual disorder or disorder of the female organs?                        | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 34. Have you had a pelvic exam and Pap smear? (Specify dates and findings of your most recent exam) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 35. Do you do a monthly breast self-exam?   | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 36. Do you take birth control pills?  | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 37. Do you use any other form of contraception? (Please specify)                                    | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

#### Men Only

- |  |                          |                          |       |
|--|--------------------------|--------------------------|-------|
| 38. Have you ever had any disorder of the penis, testicles, or prostate? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 39. Do you do a monthly testicular self-exam?                            | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Do you have any questions about your health or other matters you would like to discuss with a Health Services staff member?

- |                          |                          |       |
|--------------------------|--------------------------|-------|
| <input type="checkbox"/> | <input type="checkbox"/> | _____ |
|--------------------------|--------------------------|-------|

I hereby certify that the above is complete to the best of my knowledge.

Signed \_\_\_\_\_

Date \_\_\_\_\_



# Center for Health and Wellness

Promoting Health and Wellness that Facilitates a World of Possibilities

Keene State College  
229 Main Street  
Keene, NH 03435-2802  
603-358-2450  
603-358-2444 fax  
www.keene.edu/chw

## Comprehensive Student Health and Disability Report

### Part III: Mental Health History

*This page must be completed by the student.*

All information disclosed on this form will be kept confidential and will be shared with appropriate College personnel on a need-to-know basis only. Please return your completed report to Health Services, using the enclosed return envelope.

#### Student Information

Name \_\_\_\_\_  
Last First Middle

1. Describe any medical or mental health problems or conditions that have required psychological care. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had or experienced any of the following	Yes	No	Details: Identify questions by number, include diagnosis, age or dates, and treatment.
2. Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. An anxiety disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. An eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Bipolar disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Obsessive-compulsive disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. An anger management issue	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. PTSD	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. A suicide attempt	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Thoughts of suicide	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. Self harm (e.g., cutting)	<input type="checkbox"/>	<input type="checkbox"/>	_____
13. A sleep disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
14. Panic disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
15. A learning disability	<input type="checkbox"/>	<input type="checkbox"/>	_____
16. An anti-social or conduct disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
17. Alcohol or substance abuse or dependence	<input type="checkbox"/>	<input type="checkbox"/>	_____
18. Are you now taking or have you ever taken medication for any of the above?	<input type="checkbox"/>	<input type="checkbox"/>	_____

(specify medication and dates) \_\_\_\_\_  
\_\_\_\_\_

19. Have you been hospitalized for a psychiatric disorder?	<input type="checkbox"/>	<input type="checkbox"/>	_____
20. Have you been treated for alcohol and/or drug addiction? (specify dates)	<input type="checkbox"/>	<input type="checkbox"/>	_____
21. Are you currently being treated by:	<input type="checkbox"/>	<input type="checkbox"/>	_____
A psychotherapist (counselor, psychologist, social worker)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other mental health professional	<input type="checkbox"/>	<input type="checkbox"/>	_____
22. Would you like to receive more information on mental health services on campus? If yes, please list address.	<input type="checkbox"/>	<input type="checkbox"/>	_____



# Center for Health and Wellness

Promoting Health and Wellness that Facilitates a World of Possibilities

Keene State College  
229 Main Street  
Keene, NH 03435-2802  
603-358-2450  
603-358-2444 fax  
www.keene.edu/chw

## Comprehensive Student Health and Disability Report

---

### Part IV: Disability Information

All information disclosed on this form will be kept confidential and will be shared with appropriate College personnel on a need-to-know basis. Please return your completed report to Health Services, using the enclosed return envelope.

The Office of Disability Services, located at the Elliot Center in Elliot Hall, addresses the academic needs of students with documented physical, psychological, and learning disabilities. Accommodations may include, but are not limited to, note takers, readers, sign language interpreters, extended time for testing, books in alternative format, and use of assistive technology.

Accommodations are available upon request to those students entitled to them under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990. Filling out this form does not automatically qualify you for accommodations. To receive services, a student must provide appropriate documentation of his or her disability. Documentation of the disability should be forwarded directly to Jane Warner, Disability Service Coordinator, MS 2609. If your documentation is incomplete or inadequate for our purposes, you may be granted interim accommodations until more detailed or timely documentation can be arranged.

### Student Information

Name \_\_\_\_\_  
Last First Middle

1. What is the nature of your disability? \_\_\_\_\_  
\_\_\_\_\_

2. How and when was your disability diagnosed and documented? \_\_\_\_\_  
\_\_\_\_\_

3. What types of accommodations have you used? \_\_\_\_\_  
\_\_\_\_\_

4. What accommodations are you requesting at Keene State College? \_\_\_\_\_  
\_\_\_\_\_

5. Are there any new accommodations you anticipate requesting? If so, please specify. \_\_\_\_\_  
\_\_\_\_\_



# Center for Health and Wellness

Promoting Health and Wellness that Facilitates a World of Possibilities

Keene State College  
229 Main Street  
Keene, NH 03435-2802  
603-358-2450  
603-358-2444 fax  
www.keene.edu/chw

## Comprehensive Student Health and Disability Report

---

---

### Part V: General Wellness Information

All information disclosed on this form will be kept confidential and will be shared with appropriate College personnel on a need-to-know basis only. Please return your completed report to Health Services, using the enclosed return envelope.

#### Student Information

Name \_\_\_\_\_  
Last First Middle

Please indicate if you regularly engage in any of the following forms of exercise:

- Running
  - Walking
  - Working out
  - Swimming
  - Hiking
  - Skiing/snowboarding
  - Yoga
  - Team sports (specify) \_\_\_\_\_
  - Other (specify) \_\_\_\_\_
- 

What are your major health concerns, if any, as you come to Keene State College?

- Stress
  - Weight loss/gain/maintenance
  - Fitness
  - Healthy eating
  - Getting enough sleep
  - Avoiding illness
  - Avoiding tobacco
  - Avoiding alcohol
  - Avoiding other drugs
  - Other (specify) \_\_\_\_\_
- 

What kinds of health-oriented groups would you like to see at Keene State College?

- Weight Watchers
  - Alcoholics Anonymous
  - Walking club
  - Running club
  - Meditation group
  - Other (specify) \_\_\_\_\_
-

# Physical Examination *(To be completed by physician, ARNP, PA)*

TO THE EXAMINER: Please complete the PHYSICAL EXAMINATION below. Please comment on all pertinent findings and be sure all information is complete. \*Please include summary of the student's pertinent conditions/treatments and medications.

NAME \_\_\_\_\_ SEX: \_\_\_\_ M \_\_\_\_ F DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_

BLOOD PRESSURE \_\_\_\_\_ PULSE \_\_\_\_\_ WEIGHT \_\_\_\_\_ HEIGHT \_\_\_\_\_

VISUAL ACTIVITY: OD 20/ \_\_\_\_\_ OS 20/ \_\_\_\_\_ CORRECTIVE LENSES: ( with / without) \*please circle

## History

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| • Prior exertional chest pain  | <input type="checkbox"/> | <input type="checkbox"/> |
| • Prior exertional syncope/near syncope  | <input type="checkbox"/> | <input type="checkbox"/> |
| • Excessive, unexplained shortness of breath or fatigue with exercise  | <input type="checkbox"/> | <input type="checkbox"/> |
| • Prior history of heart murmur or increased blood pressure  | <input type="checkbox"/> | <input type="checkbox"/> |
| • Family history of premature death or morbidity from cardiovascular disease in a relative younger than age 50 | <input type="checkbox"/> | <input type="checkbox"/> |

### Exam "WNL" - or note abnormalities

MENTAL/EMOTIONAL STATUS \_\_\_\_\_

SKIN \_\_\_\_\_

HEENT \_\_\_\_\_

NECK, THYROID \_\_\_\_\_

LUNGS \_\_\_\_\_

HEART (MURMUR, DYSRHYTHMIA?) \_\_\_\_\_

ABDOMEN \_\_\_\_\_

EXTREMITIES \_\_\_\_\_

NEUROLOGICAL \_\_\_\_\_

GENITALS/HERNIA \_\_\_\_\_

### Laboratory *(if needed)*

HGB/HCT: \_\_\_\_\_ URINE: (DIP) \_\_\_\_\_

PERTINENT PAST MEDICAL/PSYCHOLOGICAL HISTORY  
*(include dates of surgeries)*

CURRENT MEDICATIONS:

ALLERGIES TO MEDICINE/FOOD/OTHER?

ANY RESTRICTIONS ON SPORTS PARTICIPATION?

PAST INJURIES	YES	NO	WHEN
Concussion(s) No.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skull fracture(s) No.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neck injuries	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shoulder injuries	<input type="checkbox"/>	<input type="checkbox"/>	_____
Elbow injuries	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arm/wrist/hand injuries	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rib cage injuries	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hip injuries	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thigh injuries	<input type="checkbox"/>	<input type="checkbox"/>	_____
Knee injuries	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lower leg injuries	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shin splints	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ankle injuries	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

HEALTH CARE PROVIDER (MD, ARNP, or PA). PLEASE PRINT NAME & ADDRESS, THEN SIGN.

MD/ARNP/PA \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ TEL. \_\_\_\_\_

SIGNATURE \_\_\_\_\_ FAX # \_\_\_\_\_

# Immunization Form

Immunization history is required by the State of New Hampshire and will be required for REGISTRATION. **Please have health care provider complete immunization record.**

Student \_\_\_\_\_ Social Security Number \_\_\_\_\_  
(please print)

Date of Birth \_\_\_\_\_

## Required for all students

A. **MMR** (Measles, Mumps, Rubella) 2 doses required \_\_\_\_\_ Dose 1 – Immunization after 12 months Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
\_\_\_\_\_ Dose 2 – Immunization after 5 years or later Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Recent titers to verify status of protection are required for students who are unable to provide documentation of MMR immunization. **Enclose of copy of titer results.**

## B. TUBERCULIN TEST (required if high risk: see Tuberculosis Risk Questionnaire)

\_\_\_\_\_ PPD (Mantoux) test within the past year Results: mm \_\_\_\_\_ Induration Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Tine or monovac not acceptable) \*Must be read by MD, ARNP, PA, RN 48-72 hrs. after receiving

\_\_\_\_\_ Positive PPD – Chest x-ray required X-Ray Result: \_\_\_\_\_ Positive \_\_\_\_\_ Negative Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Treatment type\* \_\_\_\_\_ Duration \_\_\_\_\_

\*Please provide MD report or current or past treatment

## Strongly recommended for all students

C. **VARICELLA** (Chicken pox) \_\_\_\_\_ Had Disease Date \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_ Varivax: 2 doses 4-8 weeks apart Date \_\_\_\_/\_\_\_\_/\_\_\_\_

D. **MENINGOCOCCAL** \_\_\_\_\_ Type of vaccine \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

E. **DIPHTHERIA/TETANUS/PERTUSSIS** \_\_\_\_\_ Complete primary series (DTP, DTap) Date \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_ Received TD booster within last 10 years Date \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_ Tdap Date \_\_\_\_/\_\_\_\_/\_\_\_\_

F. **POLIO** \_\_\_\_\_ Completed primary series \_\_\_\_\_ oral \_\_\_\_\_ IPV Date \_\_\_\_/\_\_\_\_/\_\_\_\_

G. **HEPATITIS B** \_\_\_\_\_ Completed vaccination series: Dose 1 Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Dose 2 Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Dose 3 Date \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_ Has report of positive immune titer (include copy) Date \_\_\_\_/\_\_\_\_/\_\_\_\_

H. **HPV** (if female) \_\_\_\_\_ Completed vaccination series Dose 1 Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Dose 2 Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Dose 3 Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## Health Care Provider (MD, ARNP, PA or RN)

MD/ARNP, PA, RN (print) \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

ADDRESS \_\_\_\_\_ Tel: \_\_\_\_\_

SIGNATURE \_\_\_\_\_

