LAKES REGION COMMUNITY COLLEGE

Health Questionnaire/Physical Exam 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. This must be completed once per academic year.

1. Name in Full: _____ Date of Birth: _____

   Home Address: _____ Telephone: _____

   _____

2. Emergency Notification:

   Name: _____ Relationship: _____

   Home Phone: _____ Work Phone_____

3. Please list all your health insurance policies. Note that students in healthcare programs or sports

   Company_____ Policy Number_____

   Name of Policyholder(s) _____

   FOR STUDENT

   I hereby grant permission to an authorized representative of the College to secure medical care as I, _____ 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 identified in Section 2.

   FOR PARENT OR GUARDIAN OF STUDENT under 18 years of age

   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 the 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 Hypoglycemic (please explain treatment)		
Ear trouble/Hearing Loss		
Epilepsy (please explain treatment)		
Eating disorder		
Eye Disease		

	YES	NO
Hepatitis		
Hernia		
High Blood Pressure		
Intestinal Problems		
Kidney Disease, Urinary Infections		
Headaches		
Mononucleosis		
Psychiatric or Emotional Problems		
Rheumatic Fever		
Stomach or Gallbladder Problems		
Thyroid Problems		
Tuberculosis		
Venereal Disease		
Heart Disease		
Other Problems		

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

_____

_____

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 physicians' continuing care for any reason, a summary from your physician concerning your treatment and medications should be submitted to the Dean of Students.

IMMUNIZATIONS

	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 Ski Test (within past year)	_____	_____
positive test requires Chest X-Ray	Results _____	
Hepatitis B Series (check program requirements)	_____	_____

Upon completion, please forward to:

LRCC
LRCC Housing Office
379 Belmont Road
Laconia NH 03246