



Health Form

Campus Life

379 Belmont Road, Laconia, NH 03246

Phone: (603) 524-3207 Fax: (603) 524-8084

Email: lrchousing@ccsnh.edu

The information allows Lakes Region Community College to provide necessary health care while you are a student. Information provided is a part of your health record, and will not influence your standing. You are required to complete

Student Name: _____ Date of Birth: _____
Home Address: _____
Telephone: _____ Program of Study: _____
Emergency Notification:
Name: _____ Relationship: _____
Home Phone: _____ Work Phone: _____
Health Insurance
Please list all your health insurance policies.
Company _____ Policy Number _____
Name of Policyholder(s) _____
Company _____ Policy Number _____
Name of Policyholder(s) _____

this form each academic year, and submit the form to the Campus Life Coordinator.

TO BE COMPLETED BY STUDENT IF OVER 18

I hereby grant permission to an authorized representative of Lakes Region Community College to secure medical care as I, _____ require, including examination, treatment and immunization. This permission is with the understanding in the event of serious illness, the College will use all reasonable efforts to contact identified in Section 2.

Signature: _____ Date: _____

TO BE COMPLETED BY PARENT OR GUARDIAN OF STUDENT IF UNDER 18

I hereby grant permission to an authorized representative of Lake Region Community College to secure such medical care as is required, including examination, treatment, and immunization. This permission is with the understanding in the event of serious illness, the College will use all reasonable effort to contact me.

Signature: _____ Date: _____

Please indicate any history of the following conditions. Explain “yes” answers in the space provided or attach an extra sheet if necessary.

Conditions	Yes	No	Comments
Alcohol or Drug Abuse			
Allergies (Food/Medicine)			
Arthritis			
Asthma (state frequency and 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			
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 Health Issues	Please explain:		

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

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

Please list any physical disabilities or handicaps:

Please list any medications or desensitization shots taken frequently or regularly:

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 Campus Life Coordinator.

Immunizations

Vaccination/Titer	Date of Vaccination/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)		
Hepatitis B Series (check program requirements)		
Positive Tuberculin Ski Test requires Chest X-Ray	Results:	