



L.P.Young Student Center
Keene State College

Medical Questionnaire
PLEASE PRINT

Name:

Local Address & Phone:

Home Address & Phone:

Class Standing: FY SO JR SR

Emergency Contact:

Relationship to you:

Contact #'s: Cell Phone/Work Phone/Home Phone

Do you have health/accident insurance? YES NO
Insurance Company and Policy #:

Are you allergic to anything? YES NO
If yes, please indicate specific allergy and type of reaction:

Are you taking any medications that could affect your participation? YES NO
If yes, indicate type, name, amount, frequency taken and reason:

Do you have or have you ever had any of the following?		
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Epilepsy or Seizures	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Fractures	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Back or Neck Injury	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Surgery in the past 2 years or that has permanent effects	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Please explain conditions marked Yes, include severity, frequency and treatment:

Do you have any physical or medical condition you think we should know about? Please explain:

Signature and Date:

