

Keene State College
Student Medical Questionnaire

PLEASE PRINT

Name: _____

Local Address and Phone: _____

Home Address and Phone: _____

Class Year: First Year Sophomore Junior Senior

Emergency Contact Name and Relationship to You: _____

Phone Number(s) for Emergency Contact: _____

Do you currently have health/accident insurance? Yes No

Insurance Company and Policy Number: _____

Do you have allergies? Yes No

If yes, please list allergy(s) and reaction: _____

Are you taking any medication(s) that could affect your participation in this event/activity?

If yes, list medication name, dosage, frequency taken and reason for taking: _____

Do you currently have or have you ever had any of the following?

Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy or Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fractures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Back or Neck Injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Surgery in the past 2 years or that has permanent effects	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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

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

Signature

Date