Keene State College
Student Medical Questionnaire

**PLEASE PRINT**

Name: _____Student ID #:_____

Students E-Mail Address: _____

Local Address: _____Phone #:_____

Home Address: _____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? ☐ Yes ☐ No

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

_____

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

| | | |
|---|---|---|
| Back, Neck, Head Injury or Concussion | ☐ Yes | ☐ No |
| Diabetes | ☐ Yes | ☐ No |
| Epilepsy or Seizures | ☐ Yes | ☐ No |
| Asthma | ☐ Yes | ☐ No |
| Heart Problems | ☐ Yes | ☐ No |
| Fractures | ☐ Yes | ☐ No |
| Surgery in the past 2 years or that has permanent effects | ☐ Yes | ☐ No |

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* *Date*

Student Organization/Club: _____