NURSING STUDENT

HEALTH & IMMUNIZATION RECORDS

****

COMPLETE THE ATTACHED HEALTH PACKET AND SUBMIT TO THE NURSING DEPARTMENT NO LATER THAN THE ASN ORIENTATION.

****

KEEP A COPY FOR YOURSELF/YOUR FILES.

WE ARE NOT PERMITTED TO DUPLICATE THESE RECORDS AFTER SUBMISSION TO THE NURSING DEPARTMENT

****

COMPLETED ORIGINAL FORMS CAN BE MAILED TO:

RIVER VALLEY COMMUNITY COLLEGE
Attn: Nursing Department
ONE COLLEGE PLACE
CLAREMONT, NH 03743

Or scan and email to Susan Cass, Executive Secretary in Nursing at scass@ccsnh.edu

Or FAX to Susan Cass at 603-543-1844

Cover updated 063015

Date: ____________________

VERIFICATION OF COMPLETED HEALTH INFORMATION RELEASE

I ____,

(Please print – Student First Name Middle Initial Last Name)

GIVE PERMISSION to River Valley Community College (RVCC) to verify the status of my Student Health and Immunization Records to my clinical affiliation sites while I am matriculated in the **Associate of Science in Nursing** program of study at RVCC.

____

Student Signature   Date

Semester to start nursing: ____

COMPLETE AND RETURN THIS PACKET TO
RVCC NURSING DEPARTMENT

RIVER VALLEY COMMUNITY COLLEGE
Nursing Department
ONE COLLEGE PLACE
CLAREMONT, NH 03743

Or scan and email to Susan Cass, Executive Secretary in Nursing at scass@ccsnh.edu

Or FAX to Susan Cass at 603-543-1844

MEDICAL HISTORY

Health Record: To be completed by all matriculated - NURSING students

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.

Name (Last, First, MI):___________________________________Date of birth:________________
Home address:____
Soc. Sec. # (last 4):______________________________________Date: ___________________

EMERGENCY NOTIFICATION
Name:____Home Phone:______________________
Relationship:____________________________________Business Phone:____________________
Home address:____

PRIMARY CARE PROVIDER
Name:___________________________________ Telephone:________________________
Address:____

INSURANCE INFORMATION: Students in nursing programs are required to provide proof of health insurance coverage. Please attach a copy of both sides of your insurance card.
Company:________________________________ Policy Number:______________

Name of policy holder(s):____

RIVER VALLEY Community College

To be completed by Student (if 18 or older)
I hereby grant permission to an authorized representative of the College to secure such medical care as I, ____, may require 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 the person identified above.

____ _____________________
Student signature Date

To be completed by Parent or Guardian (if student is under 18)
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 of parent or guardian Date

MEDICAL HISTORY

STUDENT NAME: ____ Date: ____________

1. Please list any previous illnesses or operations, and the dates, requiring hospitalization:________
____
____

2. Please list any previous fractures (broken bones) and the dates:____________________________
____

3. Please list any physical disabilities or handicaps:____
____

4. Please list any medications or desensitization shots taken frequently or regularly:_____________
____
____

5. Please indicate any history of the following conditions. Explain "YES" answers in the space provided or attach an extra sheet if necessary.

CONDITION	YES	NO	CONDITION	YES	NO
Alcohol or drug abuse			Eye disease		
Allergies (food/medicine/latex)			Gastrointestinal problems		
Arthritis			Hepatitis		
Asthma (state frequency & date of last attack)			Hernia		
Back problems			High blood pressure		
Bleeding abnormalities			Kidney disease, urinary infections		
Anxiety			Headaches		
Cancer			Infectious Mononucleosis		
Concussion (head injury)			Psychiatric or emotional problems		
Convulsions/seizures			Rheumatic fever		
Dental problems			Thyroid problems		
Diabetes or hypoglycemia (explain treatment)			Tuberculosis		
Ear trouble/hearing loss			Sexually transmitted disease		
Epilepsy (explain treatment)			Heart disease		
Eating disorder			Other problems		

Explanations:____
____
____
____

If you are under a physician's continuing care for any reason, please submit a summary from your physician concerning your treatment and medications to the Nursing Program Director.

River Valley Community College

PHYSICAL ASSESSMENT

To be completed by a Health Care Provider for all students in Nursing Programs, Allied Health Programs and Human Services and Health Technology Programs

Student name:_________________________________ID # ____________________

Height			Blood pressure	
Weight			Pulse	
Ears			Eyes	
Hearing	Right	Left	Glasses or contacts	
Nose			Abdomen	
Throat and Mouth			Genitalia	
Skin			Orthopedic Spine	
Speech			Joints	
Thyroid			Feet	
Heart			Extremities	
Lungs			Abdomen	

RIVER VALLEY Community College

____

What medication(s), if any, does the patient take regularly?_______________________

____

Please list any previous illnesses or operations, and the date that required hospitalization:____________

____

May the student participate in all normal college activities? Yes_______ No__________

If no, what is the disability?____

What are the restrictions and for how long?____________________________________

Has the applicant ever had a heart murmur, Rheumatic Fever, or any condition that would require pre-medication before dental treatment?_________________________________

Required Healthcare Provider ____

Date of Exam__________________

IMMUNIZATION RECORD

To be completed and signed by a health care provider

Student name:____ID# ________________________

Attention Healthcare Provider: *Students **MUST** have documentation proving immunity to infectious diseases **PRIOR** to attending any clinical facility associated with their program of study. Please ensure that **ALL components of this form are completed**. Your signature and printed name is vital for completion of the student immunization file.*

	Immunization requirements	**Date of Vaccine**	**Date of Results of laboratory titer**
Tetanus	Tetanus/diphtheria/ pertussis vaccine (**TDap**) within last 10 years ***pertussis documentation is required***		- - - - - - - - - - - - - - -
Mumps	MMR (if born before 1957 – NA) OR positive antibody titer		Titer date: ______________ Does this result indicate immunity? Yes No
Measles	MMR (two doses of live vaccine on or after first birthday) **OR** positive antibody titer		Titer date: ______________ Does this result indicate immunity? Yes No
Rubella	MMR (two doses of live vaccine) **OR** results of positive antibody titer		Titer date: ______________ Does this result indicate immunity? Yes No
Hepatitis B Vaccine Series	3 doses OR Signed Waiver (may be in the process of receiving and sign a waiver)	#1. #2. #3	Titer date: ______________ Does this result indicate immunity? Yes No
Chickenpox (Varicella)	History of Disease Yes_____ Year exposed ____________ **OR** Varicella Vaccine (2 doses)	#1. #2.	Titer date: ______________ Does this result indicate immunity? Yes No
Tuberculosis Screening TB	PPD/ Mantoux test Within 12 months and annually while in clinical Name of person reading PPD test:	Date given _______ Date read________ ← Name	Negative PPD Yes____No____ Positive PPD Yes____No____ When positive, did student receive treatment? (Pls. attach record) CHEST X-RAY Date: ________ Results:

X____

SIGNATURE of Health Care Provider **Date**

and PRINT ____or PROVIDER STAMP

page revised April 2014

HEPATITIS B VACCINE WAIVER

Vaccination against Hepatitis B is required for all students in the following programs:

Adventure Rec. Management
Associate Degree Nursing
Advanced Placement – RN

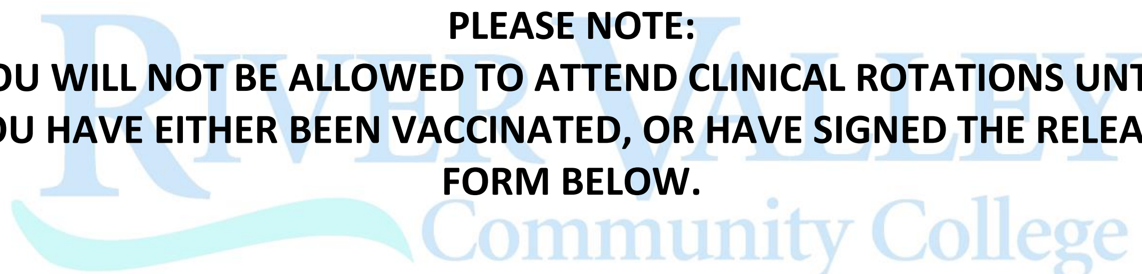
Clinical Laboratory Technician
Human Services
Early Childhood Education
Early Intervention Assistant
Massage Therapy

Medical Assistant

Occupational Therapy Assistant
Phlebotomy
Physical Therapist Assistant

Respiratory Therapy
RN – Reentry
Teacher Education

A student has the right to decline to receive the Hepatitis B Vaccine, but s/he must sign the release form provided below.



PLEASE NOTE:
YOU WILL NOT BE ALLOWED TO ATTEND CLINICAL ROTATIONS UNTIL YOU HAVE EITHER BEEN VACCINATED, OR HAVE SIGNED THE RELEASE FORM BELOW.

Student Hepatitis B Vaccine Release Form

Print Name:____

I understand that due to any clinical exposure to blood or other potentially infectious materials, I may be at risk of acquiring a Hepatitis B Viral Infection (HBV).

I release the River Valley Community College and the State of New Hampshire from any Responsibility which might arise from my refusal to comply with their request for immunization against a Hepatitis B Viral infection.

____ ___________________________
Student's signature Date