



**HEALTH & IMMUNIZATION RECORDS
For NURSING Programs**

**COMPLETE AND RETURN ALL DOCUMENTS
TO THE NURSING DEPARTMENT**

**MAKE A COPY OF THESE DOCUMENTS PRIOR TO
SUBMISSION TO THE COLLEGE**

**THE COLLEGE IS NOT PERMITTED TO
DUPLICATE THESE RECORDS.**



**ATTENTION LNA STUDENTS:
BRING COMPLETED HEALTH/IMMUNIZATION
FORMS TO THE FIRST DAY OF LNA COURSE**

COMPLETED ORIGINAL FORMS CAN BE MAILED TO:

**RIVER VALLEY COMMUNITY COLLEGE
Attention: Nursing Department
ONE COLLEGE DRIVE
CLAREMONT, NH 03743**

ASSOCIATE DEGREE NURSING STUDENTS:

Completed health packet must be returned to the Nursing Department by August 1, prior to starting the program. **KEEP A COPY**

PRACTICAL NURSING STUDENTS:

Completed health packet must be returned to the Nursing Department by the end of the summer LPN course, Nurc 110. **KEEP A COPY**

LNA STUDENTS

Bring completed packet to the first day of the LNA course. **KEEP A COPY**

Claremont, New Hampshire 03743

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 my program of study at RVCC.

Student Signature _____

Date _____

Program of Study: _____



COMPLETE AND RETURN THIS DOCUMENT TO
NURSING PROGRAM DIRECTOR

CC: Student File (Registrar's office)

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

MEDICAL HISTORY

Health Record: To be completed by all matriculated - NURSING students by August 1st.

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): _____

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.

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	

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 _____ **To be completed by a Health Care Provider**

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 complete. Your signature and printed name is vital for completion of the student immunization file.*

	Immunization requirements	Date & Type of Vaccine	Results of laboratory titer
Tetanus	Tetanus (Td) or Tetanus/diphtheria/whooping cough vaccine within last 10 years		
Mumps	MMR (if born before 1957 – NA) OR positive antibody titer		Titer: _____ Does this result indicate immunity? Yes No
Measles	MMR (two doses of live vaccine on or after first birthday) OR positive antibody titer		Titer: _____ Does this result indicate immunity? Yes No
Rubella	MMR (two doses of live vaccine) OR results of positive antibody titer		Titer: _____ 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: _____ Does this result indicate immunity? Yes No
Chickenpox (Varicella)	History of Disease Yes _____ Year exposed _____ OR Varicella Vaccine (2 doses)	#1. #2.	Titer: _____ Does this result indicate immunity? Yes No
Tuberculosis Screening TB	PPD/ Mantoux test Within 12 months and annually while in clinical	Date given _____ Date read _____ Name of person reading PPD test:	Negative PPD Yes _____ No _____ Positive PPD Yes _____ No _____ When positive, did student receive treatment? (Pls. attach record) CHEST XRAY Date: _____ Results:

X _____
SIGNATURE of Health Care Provider Date

and PRINT _____ or PROVIDER STAMP

