



Claremont, New Hampshire 03743

Date: _____

RELEASE OF HEALTH INFORMATION

I, _____,
(Please print student's first name, middle initial and last name)

GIVE PERMISSION to the River Valley Community College to release my Student Health Record and Immunizations to my clinical affiliation sites for the duration of my program of studies at the River Valley Community College.

Student Signature

Date

Program of Study: _____

PLEASE RETURN MEDICAL FORMS TO YOUR NURSING PROGRAM
DIRECTOR at:

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

Student Permanent Record Cc: Program Director

**RIVER VALLEY COMMUNITY COLLEGE
CLAREMONT**

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): _____

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 even of serious illness, the College will use all reasonable effort to contact me.

Signature of parent or guardian

Date

STUDENT NAME: _____

Date: _____

**RIVER VALLEY COMMUNITY COLLEGE
MEDICAL HISTORY FORM**

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 Program Director.

OVER

**RIVER VALLEY COMMUNITY COLLEGE
PHYSICAL - FORM**

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	

LAB WORK: Please forward the reports for the following laboratory tests to the College

Complete Blood Count	Date collected:	Urinalysis	Date collected:
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For each of the following, please indicate if the student has any history and provide the date.

CONDITION	DATE	CONDITION	DATE
Alcohol or drug abuse		Heart disease	
Epilepsy		Diabetes	
Asthma		TB or exposure to TB	
Psychiatric or emotional problems		Other	

Please explain the above: _____

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 including intercollegiate sports?
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 Signature >
Healthcare Provider _____

Date of Exam _____

To be completed by a Health Care Provider

NURSING STUDENT IMMUNIZATION RECORD

Student name: _____ **ID Number:** _____

I agree to release my immunization information and I understand that all HIPPA regulations regarding confidentiality of this information will be followed. My health record is released for use by the program director to arrange clinical placements in health care facilities throughout the program.

Student signature X _____

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 and Type of Vaccine	Results of laboratory titer
Polio	Polio		
Tetanus	Tetanus (Td) or Tetanus/diphtheria/whooping cough vaccine within last ten 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*

**RIVER VALLEY COMMUNITY COLLEGE
HEPATITIS B VACCINE WAIVER**

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

- | | |
|--------------------------------|--------------------------------|
| Adventure Rec. Management | Medical Assistant |
| Associate Degree Nursing | Nursing Assistant |
| Advanced Placement – RN | Occupational Therapy Assistant |
| Community Social Services | Phlebotomy |
| Clinical Laboratory Technician | Physical Therapist Assistant |
| Community Social Services | Practical Nursing |
| Early Childhood Education | Respiratory Therapy |
| Early Intervention Assistant | RN – Reentry |
| Human Services | Speech Language Pathology |
| IV Certification/LPN | Teacher Education |
| Massage Therapy | |

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.

I will be getting my Hepatitis B Vaccine Series and will have the results sent to the college.		
_____	_____	_____
Student's Signature	Print Last Name	Date

Student Hepatitis B Vaccine Release Form	
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

If you have an questions, please contact Admissions at (603) – 542 - 7744