HEALTH & IMMUNIZATION RECORDS

For

ALL NURSING STUDENTS

COMPLETE THE ATTACHED HEALTH PACKET AND SUBMIT TO THE NURSING DEPARTMENT BY THE REQUIRED DATE.

KEEP A COPY FOR YOURSELF/YOUR FILES

THE COLLEGE IS NOT PERMITTED TO DUPLICATE THESE RECORDS ONCE GIVEN TO THE NURSING DEPARTMENT. YOU MUST KEEP COPIES FOR YOUR PERSONAL FILES.

COMPLETED ORIGINAL FORMS CAN BE MAILED TO:

RIVER VALLEY COMMUNITY COLLEGE
Attention: Nursing Department
ONE COLLEGE PLACE
CLAREMONT, NH 03743
LNA STUDENTS

Submit completed health packet on or before the first day of the LNA course.  KEEP A COPY

******************************************************************
ASSOCIATE OF SCIENCE IN NURSING STUDENTS

Completed health packet must be returned to the Nursing Department ON or BEFORE the ASN Orientation.  KEEP A COPY

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PRACTICAL NURSING STUDENTS:

Completed health packet must be returned to the Nursing Department before the end of the LPN course, NURC110.  KEEP A COPY
August 2012
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 PLACE
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.

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

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 # _______________________

<table>
<thead>
<tr>
<th>Height</th>
<th>Blood pressure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight</td>
<td>Pulse</td>
</tr>
<tr>
<td>Ears</td>
<td>Eyes</td>
</tr>
<tr>
<td>Hearing</td>
<td>Right</td>
</tr>
<tr>
<td>Nose</td>
<td>Abdomen</td>
</tr>
<tr>
<td>Throat and Mouth</td>
<td>Genitalia</td>
</tr>
<tr>
<td>Skin</td>
<td>Orthopedic</td>
</tr>
<tr>
<td>Speech</td>
<td>Joints</td>
</tr>
<tr>
<td>Thyroid</td>
<td>Feet</td>
</tr>
<tr>
<td>Heart</td>
<td>Extremities</td>
</tr>
<tr>
<td>Lungs</td>
<td>Abdomen</td>
</tr>
</tbody>
</table>

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 healthcare 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.

<table>
<thead>
<tr>
<th>Immunization requirements</th>
<th>Date &amp; Type of Vaccine</th>
<th>Results of laboratory titer</th>
</tr>
</thead>
</table>
| Tetanus                                                      | Tetanus (Td) or Tetanus/diphtheria/whooping cough vaccine within last 10 years | Titer: ____________________  
  **Does this result indicate immunity?**  
  **Yes** | **No** |
| 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 signing a waiver) | #1. Titer: ____________________  
  **Does this result indicate immunity?**  
  **Yes** | **No**  
  #2. Titer: ____________________  
  **Does this result indicate immunity?**  
  **Yes** | **No**  
  #3 Titer: ____________________  
  **Does this result indicate immunity?**  
  **Yes** | **No** |
| Chickenpox (Varicella)                                      | History of Disease **Yes**  
  Year exposed ________________ OR Varicella Vaccine (2 doses) | #1. Titer: ____________________  
  **Does this result indicate immunity?**  
  **Yes** | **No**  
  #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_
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
- Medical Assistant
- Nursing Assistant
- Occupational Therapy Assistant
- Phlebotomy
- Physical Therapist Assistant
- Practical Nursing
- Respiratory Therapy
- RN – Reentry
- Teacher Education
- Clinical Laboratory Technician
- Human Services
- Early Childhood Education
- Early Intervention Assistant
- 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.

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