NURSING STUDENT

HEALTH & IMMUNIZATION RECORDS

******************************************************************************

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

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KEEP A COPY FOR YOURSELF/YOUR FILES.
WE ARE NOT PERMITTED TO DUPLICATE THESE RECORDS AFTER SUBMISSION TO THE NURSING DEPARTMENT

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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
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): ________________________________________________

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>
</tr>
<tr>
<td>Diabetes or hypoglycemia (explain treatment)</td>
<td></td>
<td></td>
<td>Tuberculosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ear trouble/hearing loss</td>
<td></td>
<td></td>
<td>Sexually transmitted disease</td>
<td></td>
<td></td>
</tr>
<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**

________________________________________
### 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.

<table>
<thead>
<tr>
<th>Immunization requirements</th>
<th>Date of Vaccine</th>
<th>Date of Results of laboratory titer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B Vaccine Series</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chickenpox (Varicella)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuberculosis Screening TB</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Immunization requirements**

- Tetanus/diphtheria/ pertussis vaccine *(TDap)* within last 10 years
  - *pertussis documentation is required*
  - Titer date: __________
  - Does this result indicate immunity? Yes ☐ No ☐
- MMR (if born before 1957 – NA) OR positive antibody titer
  - Titer date: __________
  - Does this result indicate immunity? Yes ☐ No ☐
- MMR (two doses of live vaccine on or after first birthday) OR positive antibody titer
  - Titer date: __________
  - Does this result indicate immunity? Yes ☐ No ☐
- MMR (two doses of live vaccine) OR results of positive antibody titer
  - Titer date: __________
  - Does this result indicate immunity? Yes ☐ No ☐
- 3 doses OR Signed Waiver (may be in the process of receiving and sign a waiver)
  - Titer date: __________
  - Does this result indicate immunity? Yes ☐ No ☐
- History of Disease Yes ☐
  - Year exposed __________
  - OR Varicella Vaccine (2 doses)
  - Titer date: __________
  - Does this result indicate immunity? Yes ☐ No ☐
- PPD/ Mantoux test
  - Within 12 months and annually while in clinical
  - Name of person reading PPD test: __________________________
  - Date given _______
  - Date read _______
  - Negative PPD Yes ☐ No ☐
  - Positive PPD Yes ☐ No ☐
  - When positive, did student receive treatment? (Pls. attach record)
  - CHEST X-RAY Date: __________
  - Results: __________________________

*Signature of Health Care Provider* __________________________

*Date* __________________________

*and PRINT ________________________________________ or PROVIDER STAMP*

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Nursing Program Director 603-542-7744 x5427 or x5368
Revised: April 2014, UPDATED June 2015
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
- 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