

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

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
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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.

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 _____

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 and the 2-step PPD 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 <i>pertussis documentation is required</i>		-----
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 A 2-step PPD indicating non-exposure is required no later than July 1, prior to starting the nursing program Use attached 2-step PPD document	PPD must be recorded on attached 2-step PPD document.	Negative PPD x 2 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

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River Valley Community College

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First year nursing students are required to submit documentation of a 2-Step Tuberculosis (TB) screening with negative result by July 01 that is valid for one year, through the spring semester.

Patient name: _____

Step One

Administration date _____ Site on patient: _____

Reading result 48 – 72 hours:

Date Read: _____ Result in mm: _____

Read by _____ Signature: _____
Print name



Step Two; 1 – 3 weeks after 1st test

Administration date _____ Site on patient: _____

Reading result 48 – 72 hours:

Date Read: _____ Result in mm: _____

Read by _____ Signature: _____
Print name

Please submit to River Valley Community College nursing department no later than July 1, prior to first semester in nursing program.

HEPATITIS B VACCINE WAIVER

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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