

REQUIRED OF:

ALLIED HEALTH STUDENTS
STUDENTS WHO PARTICIPATE IN ATHLETICS
STUDENT WHO LIVE IN A RESIDENCE HALL



Telephone: (603) 271-7153
FAX: (603) 271-7184

HEALTH REPORT FORM

Please answer all questions & keep a copy of these pages for your record.
Email: nhtihealthservices@ccsnh.edu

This information is strictly **CONFIDENTIAL** and will be used as an aid to provide necessary health care while you are a student. Information supplied will become a part of your health record, will not influence your standing at the College, and will not be released to anyone except by your written authorization.
RETURN COMPLETED FORM TO:

NHTI HEALTH SERVICES, 31 COLLEGE DRIVE, CONCORD, NH 03301

NAME _____ DOB _____ AGE _____
Last/ First/ Middle Initial

Sex M F Program of Study _____

Home Address _____ Home Phone# _____
Street
City/State/Zip

Student's Cell Phone Number _____

PARENT'S NAMES or Legal Guardian _____

Mom's work # _____ Dad's work # _____

Mom's cell # _____ Dad's cell # _____

INSURANCE INFORMATION: (PLEASE STAPLE COPY OF BOTH SIDES OF INSURANCE CARD TO THIS FORM)

NAME OF INSURANCE _____ HMO: Yes No PPO Yes No

SUBSCRIBER'S NAME _____ INS. TEL.# _____

POLICY NO.: _____ GROUP NO.: _____

PRIMARY CARE PHYSICIAN: _____ Office tel.#: _____

City/State FAX# : _____

Emergency Notification if different from above _____
Name/relationship/Phone #

I hereby grant permission to an authorized representative of NHTI to secure such medical care as may be required including examination, treatment, and immunization. In the event of an emergency, I hereby give my permission to be treated & transported to the closest emergency facility for appropriate medical treatment. I give permission for NHTI personnel to release pertinent medical/insurance information to that emergency facility, and if necessary to notify my emergency contact listed above.

Signature of Student _____ DATE _____

And/or _____ DATE _____
Parent or Guardian if student is under 18 years

I have received, read, and understand the New Hampshire Bill of Rights. SOURCE: 1981, 453:1, 1989, 43:1, effective Jan.11, 1989; effective June 19, 1992; effective August 18, 2001. View it at: <http://www.gencourt.state.nh.us/rsa/html/xi/151/151-21.htm>

SIGNATURE _____ DATE _____
Student

STUDENT NAME _____

D.O.B. _____

Your (student's) PAST OR PRESENT HISTORY OF: (Circle if any issues have pertained to YOU and explain below)

- | | | | |
|----------------------------|---------------------------------|----------------------|---------------------------------|
| Anemia | Dizziness /Fainting / Blackouts | Intestinal Problems | Sexually Transmitted Diseases |
| Anxiety | Drug or Alcohol Issues | Joint Disease | Sickle Cell Disease / Trait |
| Asperger's Disorder | Eating Disorder | Kidney Disease | Skin Disorders |
| Asthma / Lung Disorders | Emotional Problems | Learning Disability | Sleep Issues |
| Bi-Polar Disorder | Epilepsy / Convulsions | Leukemia | Staphylococcal Infection / MRSA |
| Bleeding abnormal | Head Injury / Concussion | Migraine headaches | Stomach Problems |
| Cancer / Impaired Immunity | Hearing Loss | Mononucleosis | Thyroid Disorder |
| Chicken Pox | Heart Disease or Murmurs | Orthopaedic Injuries | Weight Issues |
| Depression | Hepatitis | Schizophrenia | |
| Diabetes | HIV Infections / AIDS | Seizures | |

EXPLAIN ALL / & or OTHER: _____

CURRENT MEDICATION by prescription or over the counter (List includes birth control pills, herbal and sport related supplements)

Sleep _____ hours a night

Current weight _____ lbs :: ideal weight you would like to see _____ lbs Hospitalizations _____

Alcohol consumption a week _____ Surgeries _____

(Street) Drug use _____

Cigarettes _____ a day Tobacco Use _____ a day

Exercise _____ times a week

Dietary needs _____

Allergic to: _____
Reaction: _____

Do / Should you have an epi-pen Yes or No

Have you received mental health services In-patient _____ or Out-patient _____ Explain _____

FAMILY HISTORY Circle if ANY OF YOUR BLOOD RELATIVES HAVE OR HAD – grandparents, parents, siblings, and blood aunt/uncle

RELATION	RELATION
Allergies _____	Epilepsy/Convulsions _____
Alcoholism/Drug Abuse _____	Familial Disease _____
Asthma _____	Heart Disease _____
Autism _____	Intestinal Problems _____
Bleeding, abnormal _____	Kidney Disease _____
Bi-Polar Disease _____	Lung Disease/TB _____
Bone Disorders/osteoporosis _____	Migraine Headache _____
Cancer and/or impaired immunity _____	Stomach Problems _____
Depression/Suicide _____	Schizophrenia _____
Diabetes _____	Please indicate if you are adopted _____
Any family member died before the age of 55, list cause of death _____	

IMMUNIZATIONS: TO BE COMPLETED BY YOUR HEALTHCARE PROVIDER

All information must be in English.

NAME OF STUDENT _____ Date of birth _____

MMR: 2 doses (after 1980). First dose on or after 12 months of age. Second dose at least 28 days after the first dose.

MMR#1 _____ MMR#2 _____

Must have MMR dates or laboratory evidence of immunity (titer).

MMR titer: Measles (date & results) _____ Mumps _____ Rubella _____

Tetanus (Td): (Within 10 years of primary series) _____

Tetanus, diphtheria and attenuated pertussis (Tdap): _____ (Allied Health students with patient contact should receive a single dose of Tdap at an interval of 2 years from the last Td)

Tuberculin Skin Test (Mantoux 5TU PPD)

Initial two step testing required for all Allied Health students before the start of classes, then one TB test annually. International students must have one TB test within 30 days from start of college.

Date given _____ Date Read _____ Result _____ (Record actual mm of induration: if no induration, write "0").

Date given _____ Date Read _____ Result _____ (Record actual mm of induration if no induration, write "0").

Chest X-Ray (required if tuberculin test is positive) Result: _____ Date of Chest X-ray _____

Hepatitis B Vaccine Series (Required for ALL Allied Health Students)

#1 _____

#2 _____

#3 _____

Hepatitis B Surface Antibody Screen (titer) is required if Hepatitis B vaccine series was received within the past 6 months.

Date & Result _____

Meningococcal (MCV4) Vaccine: Date: _____

Dates of Chickenpox (Varicella) Immunizations: #1 _____ #2 _____

OR

Date and Results of Varicella Titer: _____

HEALTHCARE PROVIDER MUST COMPLETE THIS PAGE (AND SIGN BELOW)

Student Name: _____

Date of Birth _____

Date of Physical Examination _____

Height _____

Weight _____

Blood Pressure _____

Pulse _____

Eyes _____

Glasses _____

Contacts _____ Last eye exam _____

Visual Acuity – (L) OS _____ (R) OD _____ OU _____

Ears _____

Hearing: Right _____

Left _____

Throat and mouth _____

Speech _____

Thyroid _____

Skin _____

Heart _____

Lungs _____

Abdomen _____

Orthopedic _____

Spine _____

Feet _____

Joints _____

Extremities _____

May the student participate in all normal college activities including intercollegiate sports?

Yes _____ No _____

If no, what is the disability? _____

What are the restrictions? _____

Time period of restrictions _____

Has the applicant ever had a heart murmur, Rheumatic fever, or any other condition that would require premedication before dental treatment? _____

If student is under a health care provider's continuing care for any reason, a summary from the health care provider regarding his/her treatment and medications must be included in this questionnaire.

HEALTH CARE PROVIDER SIGNATURE: _____

Please print name: _____

Address: _____ Date _____ Phone _____

PLEASE COMPLETE THIS FORM AND RETURN BEFORE CLASSES BEGIN:

**NHTI HEALTH SERVICES
31 COLLEGE DRIVE
CONCORD, NH 03301-7412**