NHTI
Concord's Community College

TEL (603) 230-4043

FAX (603) 230-9308

ALLIED HEALTH STUDENT - Health History Form

NHTI Health & Counseling Services
31 College Drive
Concord, NH 03301-7412
nhtihealthservices@ccsnh.edu

This information is strictly **CONFIDENTIAL** and will be used as an aid to provide necessary healthcare 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 outside of Health & Counseling except by your written authorization.

This entire form must be completed by all Allied Health students. **Health information must be documented on this form** with additional documentation attached as needed. This report must be accompanied by a copy of BLS for Healthcare Provider CPR card and Insurance Card.

Name _____ DOB _____ Age _____
Last First Middle Initial

Program of Study _____ Student ID# _____

Campus Housing ☐ Yes ☐ No Sports ☐ Yes ☐ No If yes, which sport: _____

Sex: ☐ M ☐ F ☐ Other _____ ☐ Decline to answer Veteran: ☐ Yes ☐ No ☐ Decline to answer

Race: ☐ Black ☐ White ☐ Hispanic/Latino ☐ Native American ☐ Asian / Asian Pacific ☐ Multi-racial ☐ Decline to answer

Home Address _____ Home Phone#_____
Street

_____ Student's Cell _____
City/State/Zip

Student email _____

Emergency Contact _____ Relationship to student _____

Contact's Home # _____ Contact's work # _____

☐ I have received, read, and understand the New Hampshire Bill of Rights/complaint procedure. **Source.** eff. Jan. 1, 2014 (PLEASE CHECK BOX)

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

Student Name _____ D.O.B._____

Student's Past History: (CIRCLE if any issues have pertained to YOU and explain below)

ADD/ADHD	Dizziness / Fainting / Blackouts	Intestinal Problems	Self Injury
Anemia	Drug or Alcohol Issues	Joint Disease	Sexually Transmitted Diseases
Anxiety	Eating Disorder	Kidney Disease	Sickle Cell Disease / Trait
Asperger's Disorder	Emotional Problems	Learning Disability	Skin Disorders
Asthma / Lung Disorders	Epilepsy / Convulsions	Leukemia	Sleep Issues
Bi-Polar Disorder	Head Injury / Concussion	Migraine Headaches	Staph Infections / MRSA
Bleeding Abnormal	Hearing Loss	Mononucleosis	Stomach problems
Cancer / Impaired Immunity	Heart Disease or Murmurs	OCD	Thyroid Disorder
Chicken Pox	Hepatitis	Orthopedic Injuries	Weight Issues
Depression	High Blood Pressure	PTSD	Other
Diabetes	HIV Infection / AIDS	Seizures	

Explain Each Circled Area: **N/A** ☐ _____

_____

_____

Current Medications: prescription or over-the-counter (including birth control or herbal supplements.) **N/A** ☐

_____

_____

Special Dietary Needs: **N/A** ☐ _____

Sleep _____hours a night

Overnight Hospitalizations_____

Current weight _____lbs: Ideal weight you would like to see _____lbs

Surgeries_____

Exercise _____times a week

Alcohol consumption a week _____

(Street) Drug use _____

Cigarettes _____ a day Tobacco Use _____a day

Drug/Food Allergies: N/A ☐ **Allergen:** _____ Reaction: _____

Do you have an EpiPen ? **Yes** ☐ **No** ☐ If yes, explain: _____

Latex allergy? Yes ☐ **No** ☐ **Not sure** ☐

Environmental / Seasonal Allergies: Yes ☐ No ☐ _____

Mental Health Services: N/A ☐ In-patient ☐ Out-patient ☐

When? _____

Where? _____

Family History: Please indicate if any blood relatives have had any of the following. Please indicate their relation to you.

Cancer _____ Heart Disease _____

Diabetes _____ Substance Abuse _____

Mental Health Issues _____ Other: _____

Depression/Suicide_____

Any family member die before the age of 55, list cause of death _____

Student Name _____ D.O.B._____

ALLIED HEALTH IMMUNIZATION REQUIREMENTS		
***MMR 1:**		**Measles Titer:** **CIRCLE ONE**: positive or negative
(mm/dd/yyyy)	**OR**	(mm/dd/yyyy)
***MMR 2:**		**Mumps Titer:** **CIRCLE ONE**: positive or negative
(mm/dd/yyyy)		(mm/dd/yyyy)
		Rubella Titer: **CIRCLE ONE**: positive or negative
		(mm/dd/yyyy)

*Either two MMRs given **AFTER** 1980

Hepatitis B Series – TITER IS REQUIRED
Hepatitis B #1:
(mm/dd/yyyy)
Hepatitis B #2:
(mm/dd/yyyy)
Hepatitis B #3:
(mm/dd/yyyy)
Hepatitis B Antibody Titer:
(mm/dd/yyyy)
CIRCLE ONE: positive or negative

2nd HepB Series w/Titer if 1st series titer is NEGATIVE
Hepatitis B #4:
(mm/dd/yyyy)
Hepatitis B #5:
(mm/dd/yyyy)
Hepatitis B #6:
(mm/dd/yyyy)
Hepatitis B 2nd Antibody Titer:
(mm/dd/yyyy)
CIRCLE ONE: positive or negative

Tuberculin Skin Test (TST)		**T-Spot or Interferon Gold**
TB Test #1: Date given	**OR**	**IGRA:**
(mm/dd/yyyy)		(mm/dd/yyyy)
Date read		**CIRCLE ONE**: positive or negative
(mm/dd/yyyy)		***Attach treatment plan if applicable.**
Results in mms:		
TB Test #2: Date given		
(mm/dd/yyyy)		
Date read		
(mm/dd/yyyy)		
Results in mms:		
***If there is a positive TST test, an IGRA or a T-Spot is REQUIRED.**		
TDAP: (required)		**TD: (also required if this is more recent than TDAP)**
(mm/dd/yyyy)		(mm/dd/yyyy)

Student Name: _____ Date of Birth_____

Date of Physical Exam _____ (within 12 months of admission)

Height_____

Weight_____

BP _____ Pulse _____

Eyes _____

Glasses/ Contacts _____

Last eye exam _____

Visual Acuity – (L) OS_____ (R) OD _____ OU_____

Ears_____

Hearing: Right_____ Left_____

Females: Menses: Frequency _____

Duration _____

Issues _____

Throat and mouth_____

Thyroid_____

Skin _____

Heart_____

Lungs_____

Abdomen_____

Orthopedic_____

Spine_____

Feet_____

Joints_____

Extremities_____

May the student participate in all normal college activities including intercollegiate sports? ☐ Yes ☐ No
May the student participate in clinical rotations if applicable? ☐ Yes ☐ No ☐ NA
Is the student medically clear to live independently in Campus Housing? ☐ Yes ☐ No

Has the student ever had a heart murmur, Rheumatic fever, or any other condition that would require pre-medication before dental treatment? ☐ Yes ☐ No

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

By signing this page, I acknowledge that I have reviewed and can confirm the information contained on pages 3 & 4 of this form.

Healthcare Provider signature:_____

Please print name: _____

Address: _____ Date_____ Phone_____

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RESIDENTIAL CARE AND HEALTH FACILITY LICENSING

Patients' Bill of Rights

PLEASE KEEP THIS COPY FOR YOUR RECORDS

Section 151:21

151:21 Patients' Bill of Rights. –

The policy describing the rights and responsibilities of each patient admitted to a facility, except those admitted by a home healthcare provider, shall include, as a minimum, the following:

I. The patient shall be treated with consideration, respect, and full recognition of the patient's dignity and individuality, including privacy in treatment and personal care and including being informed of the name, licensure status, and staff position of all those with whom the patient has contact, pursuant to RSA 151:3-b.

II. The patient shall be fully informed of a patient's rights and responsibilities and of all procedures governing patient conduct and responsibilities. This information must be provided orally and in writing before or at admission, except for emergency admissions. Receipt of the information must be acknowledged by the patient in writing. When a patient lacks the capacity to make informed judgments the signing must be by the person legally responsible for the patient.

III. The patient shall be fully informed in writing in language that the patient can understand, before or at the time of admission and as necessary during the patient's stay, of the facility's basic per diem rate and of those services included and not included in the basic per diem rate. A statement of services that are not normally covered by Medicare or Medicaid shall also be included in this disclosure.

IV. The patient shall be fully informed by a healthcare provider of his or her medical condition, healthcare needs, and diagnostic test results, including the manner by which such results will be provided and the expected time interval between testing and receiving results, unless medically inadvisable and so documented in the medical record, and shall be given the opportunity to participate in the planning of his or her total care and medical treatment, to refuse treatment, and to be involved in experimental research upon the patient's written consent only. For the purposes of this paragraph "healthcare provider" means any person, corporation, facility, or institution either licensed by this state or otherwise lawfully providing healthcare services, including, but not limited to, a physician, hospital or other healthcare facility, dentist, nurse, optometrist, podiatrist, physical therapist, or psychologist, and any officer, employee, or agent of such provider acting in the course and scope of employment or agency related to or supportive of healthcare services.

V. The patient shall be transferred or discharged after appropriate discharge planning only for medical reasons, for the patient's welfare or that of other patients, if the facility ceases to operate, or for nonpayment for the patient's stay, except as prohibited by Title XVIII or XIX of the Social Security Act. No patient shall be involuntarily discharged from a facility because the patient becomes eligible for Medicaid as a source of payment.

VI. The patient shall be encouraged and assisted throughout the patient's stay to exercise the patient's rights as a patient and citizen. The patient may voice grievances and recommend changes in policies and services to facility staff or outside representatives free from restraint, interference, coercion, discrimination, or reprisal.

VII. The patient shall be permitted to manage the patient's personal financial affairs. If the patient authorizes the facility in writing to assist in this management and the facility so consents, the assistance shall be carried out in accordance with the patient's rights under this subdivision and in conformance with state law and rules.

VIII. The patient shall be free from emotional, psychological, sexual and physical abuse and from exploitation, neglect, corporal punishment and involuntary seclusion.

IX. The patient shall be free from chemical and physical restraints except when they are authorized in writing by a physician for a specific and limited time necessary to protect the patient or others from injury. In an emergency, restraints may be authorized by the designated professional staff member in order to protect the patient or others from injury. The staff member must promptly report such action to the physician and document same in the medical records.

X. The patient shall be ensured confidential treatment of all information contained in the patient's personal and clinical record, including that stored in an automatic data bank, and the patient's written consent shall be required for the release of information to anyone not otherwise authorized by law to receive it. Medical information contained in the medical records at any facility licensed under this chapter shall be deemed to be the property of the patient. The patient shall be entitled to a copy of such records upon request. The charge for the copying of a patient's medical records shall not exceed $15 for the first 30 pages or $.50 per page, whichever is greater; provided, that copies of filmed records such as radiograms, x-rays, and sonograms shall be copied at a reasonable cost.

XI. The patient shall not be required to perform services for the facility. Where appropriate for therapeutic or diversional purposes and agreed to by the patient, such services may be included in a plan of care and treatment.

XII. The patient shall be free to communicate with, associate with, and meet privately with anyone, including family and resident groups, unless to do so would infringe upon the rights of other patients. The patient may send and receive unopened personal mail. The patient has the right to have regular access to the unmonitored use of a telephone.

XIII. The patient shall be free to participate in activities of any social, religious, and community groups, unless to do so would infringe upon the rights of other patients.

XIV. The patient shall be free to retain and use personal clothing and possessions as space permits, provided it does not infringe on the rights of other patients.

XV. The patient shall be entitled to privacy for visits and, if married, to share a room with his or her spouse if both are patients in the same facility and where both patients consent, unless it is medically contraindicated and so documented by a physician. The patient has the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, including choice of room and roommate, except when the health and safety of the individual or other patients would be endangered.

XVI. The patient shall not be denied appropriate care on the basis of race, religion, color, national origin, sex, age, disability, marital status, or source of payment, nor shall any such care be denied on account of the patient's sexual orientation.

XVII. The patient shall be entitled to be treated by the patient's physician of choice, subject to reasonable rules and regulations of the facility regarding the facility's credentialing process.

XVIII. The patient shall be entitled to have the patient's parents, if a minor, or spouse, or next of kin, or a personal representative, if an adult, visit the facility, without restriction, if the patient is considered terminally ill by the physician responsible for the patient's care.

XIX. The patient shall be entitled to receive representatives of approved organizations as provided in RSA 151:28.

XX. The patient shall not be denied admission to the facility based on Medicaid as a source of payment when there is an available space in the facility.

XXI. Subject to the terms and conditions of the patient's insurance plan, the patient shall have access to any provider in his or her insurance plan network and referral to a provider or facility within such network shall not be unreasonably withheld pursuant to RSA 420-J:8, XIV.

Source. 1981, 453:1. 1989, 43:1. 1990, 18:1-6; 140:2, XI. 1991, 365:10. 1992, 78:1. 1997, 108:6; 331:3-8. 1998, 199:2; 388:5, 6. 2001, 85:1, eff. Aug. 18, 2001. 2009, 252:1, eff. Sept. 14, 2009. 2013, 265:3, eff. Jan. 1, 2014.

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INFORMED RISK INSURANCE FORM FOR ALLIED HEALTH STUDENTS

I am aware that in the course of my clinical studies, there is a potential risk for me to be in contact with clients who are either infected with or are carriers of infectious disease such as Hepatitis B, AIDS, herpes, tuberculosis, or other such chronic serious disease processes.

It is for this reason that faculty of all Allied Health programs (such as Nursing, Dental Auxiliaries, Radiology, Radiation, Orthopaedics, Sonography & Paramedic), working in conjunction with outside clinical supervisors, carefully instruct students in the proper techniques of collecting relevant medical data from their clients, recording medical histories and reviewing client records. In addition, they instruct students in state-of-the-art methods of disinfection, sanitization and sterilization to prevent cross contamination from client to client, client to operator, and operator to client. Students are expected to adhere to standard precautions and follow accepted OSHA guidelines while performing all clinical procedures both on campus and at outside clinic affiliations. Before working with clients in clinic, students are advised that they should be vaccinated for the Hepatitis B virus. If students choose not to receive the Hepatitis B vaccine, they must sign a waiver, stating that they take responsibility for their own personal health. **The ultimate responsibility for the prevention of self-contamination from infectious diseases rests solely with the individual student.**

All Allied Health students are required to carry appropriate health insurance coverage. All students must be aware of what their individual insurance coverage provides (particularly in the event of an accidental needle stick) while performing their duties in a student capacity. Students are urged to be knowledgeable as to their insurance coverage to ensure that their potential needs will be met.

*****

By my signature on this document, I verify that I have read and understand the above information and I agree to provide Health Services personnel with information regarding any changes of my health insurance coverage or provider.

_____ _____

Print Name Date

_____

Student Signature

_____

Parent (If Student under age 18)

Proof of Insurance and BLS for Healthcare Provider CPR

Please be sure to attach:

1. a copy of your insurance card, and
2. a copy of your BLS for Healthcare Provider CPR card.

If you have questions about whether your CPR card meets our requirements, contact us: nhtihealthservices@ccnsh.edu or 603.230.4043.