NHTI
Concord's Community College

TEL (603) 230-4043

FAX (603) 230-9308

Health Report Form

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.

Name _____ DOB _____ Age _____
Last First Middle Initial

Sex ☐ M ☐ F Program of Study _____ Student ID# _____

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

Home Address _____ Home Phone#_____
Street

_____ Student's Cell _____
City/State/Zip

Emergency Contact _____ Relationship to student _____

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

INSURANCE INFORMATION: (ATTACH A COPY 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. #: _____

_____ FAX#: _____
City/State

☐ 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)

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

Explain Each Circled (Write N/A if none): _____

_____

_____

Current Medication: prescription or over the counter (Include birth control, herbal and supplements.) **Write N/A if none**

_____

_____

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

Sleep _____hours a night

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

Exercise _____times a week

Alcohol consumption a week _____

(Street) Drug use _____

Cigarettes _____ a day Tobacco Use _____a day

Overnight Hospitalizations_____

Surgeries_____

(**Females**) Menstrual Cycle: Frequency_____

Duration _____

Problems: _____

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

_____

Do you have en Epi-pen ? ☐ **Yes** ☐ **No** If yes, explain: _____

Environmental / Seasonal Allergies: _____

Mental Health Services: **N/A** ☐ In-patient _____ or Out-patient _____ When? _____

Where? _____

Family History: Circle if any of your blood relatives (grandparents, parents, siblings, and blood aunt/uncle) have or have had:

	Relation		**Relation**
Allergies	_____	Epilepsy/Convulsions	_____
Alcoholism/Drug Abuse	_____	Familial Disease	_____
Asthma	_____	Heart Disease / High Blood Pressure	_____
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_____

Student Name _____ D.O.B._____

Immunizations: *To be completed by a Healthcare Provider* ****

SECTION 1: Required for all Allied Health students, Housing and Sports

MMR (2 shots after 1980 or MMR titers) MMR #1_____ MMR #2 _____

MMR titer (date & results): Measles_____Mumps_____ Rubella_____

MMR booster for negative / equivocal titer: Date: _____

Tetanus: _____ Tdap: _____ (History of 1 Tdap is required for Health Students)

SECTION 2: Required for all Allied Health or High Risk Students Only

Tuberculin Skin Test (TST): Initial two step testing required for all Allied Health students within 1 year of starting program, then one test annually. Two step testing is done 1 – 3 weeks apart. IGRA blood test may replace TST and XRay.

Date given_____ Date Read_____ Result_____ (Record actual mm of induration).

Date given_____ Date Read_____ Result_____ (Record actual mm of induration).

Interferon-gamma release assays (IGRA or T-Spot) result _____

Chest X-Ray (With positive TST) Result: _____ Date of Chest X-ray (within 5 yrs)_____

Hepatitis B Vaccine Series (3 Hepatitis shots or a positive Hepatitis B titer). A Hep B titer is required if the Hepatitis B Series was completed within the last 6 months.

#1_____ #2_____ #3_____

Hepatitis B Surface Antibody Titer: Date_____ Result _____ Booster: _____

Varicella (2 shots or positive titer only)

Varicella #1 _____ Varicella #2 _____ **OR** Varicella Titer Date_____ Result _____

SECTION 3: (OPTIONAL) – Annual Flu may be required by some clinical sites

Flu Shot: Date _____

Meningococcal: Dates _____, _____ Meningitis B: Dates _____, _____

*** Healthcare Provider Initial _____ ****

To be completed by a Healthcare Provider (initial page 3 and sign below)****

Student Name: _____ Date of Birth_____

Date of Physical Examination_____

Height_____ Speech_____

Weight_____ Thyroid_____

Blood Pressure_____ Skin _____

Pulse_____ Heart_____

Eyes_____ Lungs_____

Glasses_____ Abdomen_____

Contacts _____ Last eye exam_____ Orthopedic_____

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

Ears_____ Feet_____

Hearing: Right_____ Joints_____

Left _____ Extremities_____

Throat and mouth_____

May the student participate in all normal college activities <u>including</u> intercollegiate sports? ☐ Yes ☐ No

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

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

Healthcare Provider Signature: _____

Please print name: _____

Address: _____ Date_____ Phone_____

Please complete this form & return <u>prior to the beginning of classes, sports or move – in day</u>

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