NHTI
Concord's Community College

TEL (603) 230-4043

FAX (603) 230-9308

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.

Name _____ Date of Birth _____ Age _____
Last First Middle Initial

Preferred Name (if applicable) _____ Student ID# _____

Academic Major _____ Sports ☐ Yes ☐ No Campus Housing ☐ Yes ☐ No

Home Address _____ Student Cell #_____
Street

_____ Student email _____
City/State/Zip

Emergency Contact _____ Relationship to student _____

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

Preferred Pronoun:	**Gender Identity:**	**Race:**
o He	o F	o African/Black
o She	o M	o Asian / Asian Pacific
o They	o Transgender Female	o Caucasian
o Ze	o Transgender Male	o Hispanic / LatinX
o Other _____	o Other _____	o Multi – Racial
		o Native American
		o Other _____

☐ 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 _____

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

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

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 _____

Drug use _____

Cigarettes _____ a day Tobacco Use _____a day Vape / e-Cigarette _____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 ☐

Alcohol / Substance Abuse Services: N/A ☐ In-patient ☐ Out-patient ☐

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

Cancer _____ Heart Disease _____
Diabetes _____ Alcohol / Substance Abuse _____
Mental Health Issues _____ Other: _____
Suicide_____
Any family member die before the age of 55, list cause of death _____

RESIDENTIAL CARE AND HEALTH FACILITY LICENSING

Patient’s Bill of Rights

STUDENTS: PLEASE KEEP THIS BILL OF RIGHTS 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.

NHTI Health & Counseling Services
Physical Exam Form

31 College Drive
Concord, NH 03301-7412
nhtihealthservices@ccsnh.edu
TEL (603) 230-4043 FAX (603) 230-9308

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_____
Orthopaedic_____
Spine_____
Feet_____
Joints_____
Extremities_____

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.

By signing this page, I acknowledge that I have examined the student and they may participate in all normal college activities including intercollegiate sports, clinical rotations and may live independently on campus unless otherwise noted.

Healthcare Provider Signature:_____

Please print name: _____

Address: _____ Date_____ Phone_____

*Please sign page 2 or attach immunizations

Student Name _____ **D.O.B.**_____

RESIDENCE LIFE or SPORTS IMMUNIZATION REQUIREMENTS

MMR (both given after 1980)
MMR 1:
(mm/dd/yyyy)
MMR 2:
(mm/dd/yyyy)

OR

MMR Titer	
Measles Titer:	**CIRCLE ONE**: positive or negative
(mm/dd/yyyy)	
Mumps Titer:	**CIRCLE ONE**: positive or negative
(mm/dd/yyyy)	
Rubella Titer:	**CIRCLE ONE**: positive or negative
(mm/dd/yyyy)	

TDAP:
TDAP
(mm/dd/yyyy)

OR

Tetanus
Td
(mm/dd/yyyy)

If you are planning on participating in sports, you are required to attach a copy of your insurance.

******** **Name of Provider completing form**: _____ ********