

HEALTH REPORT FORM

REQUIRED OF Students Who Participate in Athletics
Please answer all questions and keep a copy for your record.

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 permission.

Name: _____ DOB: ____/____/____ Age: _____
Last First M.I. Month Day Year

Gender: Male Female

Home Address: _____
Street City State ZIP

Home Phone: (____) _____ Cell Phone: (____) _____

Parent's/Legal Guardian's Name:

Father: _____ Cell Phone: (____) _____ Work: (____) _____

Mother: _____ Cell Phone: (____) _____ Work: (____) _____

Emergency Notification if different from above

Name Relationship Phone

INSURANCE INFORMATION (PLEASE ATTACH A COPY OF BOTH SIDES OF YOUR INSURANCECARD)

NAME OF INSURANCE: _____ HMO: Yes No PPO: Yes No

SUBSCRIBER'S NAME: _____ INS TEL. (____) _____

POLICY NO.: _____ GROUP NO.: _____

PRIMARY CARE PHYSICIAN: _____ OFFICE TEL.: _____

CITY AND STATE FAX: _____

I hereby grant permission to an authorized representative of NCC to secure such medical care as may be required including, but not limited to, examination, treatment, and examination. In the event of an emergency, I hereby give my permission to be treated and transported to the closest emergency facility for appropriate medical treatment. I give permission for NCC to release pertinent medical/insurance information to that emergency facility, and if necessary to notify my emergency contact above.

Student's Signature: _____ Date: ____/____/____

Parent/Guardian's Signature (If student is under 18) _____ Date: ____/____/____

I have received, read, and understood the N.H. Bill of Rights. Source: 1981, 453:1, 1989, 43:1, effective Jan. 11, 1989; effective June 19, 1992; effective August 18, 2001.

Student's Signature: _____ Date: ____/____/____

Student's Name: _____ Date: ____/____/____

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 and 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/Convulsion | 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 | Orthopedic Injuries | Weight Issues |
| Depression | Hepatitis | Schizophrenia | Other: _____ |
| Diabetes | HIV Infections/AIDS | Seizure | Other: _____ |

Explain all you have circled: _____

Current Medication by Prescription or Over the Counter (List includes birth control pills, herbal and sport related supplements)

Sleep _____ hours per night

Current weight _____ lbs. - Ideal weight you would like to see _____ lbs.

Hospitalizations _____

Alcohol consumption a week _____ Surgeries: _____

Illicit drug use _____ Menstrual Cycle Frequency: _____

Cigarettes _____ per day Tobacco use _____ per day duration _____

Exercise _____ times per day problems _____

Dietary needs _____

Please list any allergies you might have _____

Do/should you have an epi-pen Yes No

Have you received mental health services? Yes No In-patient Out-patient

Please explain: _____

Family History. Circle if any of your blood relatives have or had any of the following:

	Relationship		Relationship
Allergies	_____	Epilepsy/Convulsions	_____
Alcoholism/Drug Use	_____	Familial Disease	_____
Asthma	_____	Heart Disease	_____
Autism	_____	Intestinal Problems	_____
Abnormal Bleeding	_____	Kidney Disease	_____
Bi-Polar Disease	_____	Lung Disease	_____
Osteoporosis	_____	Migraine Headache	_____
Cancer and/or Impaired Immunity	_____	Stomach Problems	_____
Depression/Suicide	_____	Schizophrenia	_____
Diabetes	_____	Were 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. 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 on laboratory evidence of immunity (titer).

MMR Titer: Measles (date of 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 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: ____/____/____

Year of chicken pox disease _____ or date of immunization (Varivax) #1 _____
#2 _____

Healthcare Provider Must Complete This Page

Student's Name: _____ Date of Birth: ____/____/____

Date of Physical Examination: ____/____/____

Height	_____	Speech	_____
Weight	_____	Thyroid	_____
Blood Pressure	_____	Skin	_____
Pulse	_____	Heart	_____
Eyes	_____	Lungs	_____
Glasses	_____	Abdomen	_____
Contacts _____ Last 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 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 murmur, rheumatic fever, or any other condition that would require premedication before dental treatment? _____

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

Healthcare Provider's Signature _____ Date: ____/____/____

Please Print Your Name _____

Address: _____
 Street City/Town State ZIP

PLEASE COMPLETE AND RETURN THIS FORM TO THE ATHLETICS OFFICE.