HARMONY HEALTH CARE INSTITUTE, INC.

10 Al Paul Lane, Suite 204, Merrimack, NH 03054
603-886-0822, Toll Free: 877-886-0822 • Fax: 603-886-0877
www.harmony-health.org

Health Status Verification / Physical Exam Form

Directions:

- Required of all students
- Please print or type
- Must be submitted 7 days prior to start of class
- The information provided on this form is used strictly for student health status verification and will not be released to anyone without the student's knowledge and consent.
- All students must complete this form and have it signed by a medical provider. Failure to complete this form before the course start date will result in removal from class.

Name: Date of Birth:

_____ _____
Last First Middle Month / Date / Year

_____ _____ _____ _____ _____ _____
Gender Race Religion Marital Status Citizenship Country of Birth

Social Security Number (if available):_____ Home telephone: _____

Home Address:_____
Number and Street

_____
City State Zip Country

Parent or Legal Guardian: _____
Name

_____
Address and telephone if different from above

Who should we contact in case of emergency, if different from above?

Name: _____ Telephone: _____

E-mail Address: _____

Medical History

Allergies

Type *(food, medication, other)* Reaction

1. _____
2. _____
3. _____

Medical History / Physical Exam *(page 2 of 3)*

Current Medications

	Name of medication	Dosage	Reason for medication
1.			
2.			
3.			
4.			

Hospitalization and / or Surgery

Date Description

_____

_____

Medical Illnesses or Problems

Illness or problem Explanation

- ❑ Heart disease (*hypertension, etc.*)_____
- ❑ Endocrine problem (*thyroid, diabetes, etc.*)_____
- ❑ Epilepsy (*seizure disorder*)_____
- ❑ Chemical dependency (*alcoholism, etc.*)_____
- ❑ Pulmonary problem (*bronchitis, asthma, pneumonia, etc.*)_____
- ❑ Eating disorder (*anorexia nervosa, bulimarexia*)_____
- ❑ Depression / anxiety_____
- ❑ Other_____

Family History

Relative	Age	State of Health	If deceased, cause of death
Father			
Mother			
Siblings			

Has any blood relative (maternal or paternal grandparents, parents, siblings) had any of the following?

Relationship Explanation (e.g., heart attack)

- Diabetes ❑ Yes ❑ No_____
- Heart trouble ❑ Yes ❑ No_____
- Breast cancer ❑ Yes ❑ No_____
- Cancer ❑ Yes ❑ No_____
- Seizure disorder ❑ Yes ❑ No_____
- Substance abuse ❑ Yes ❑ No_____
- Other ❑ Yes ❑ No_____

Social Habits

Do you smoke? ❑ Yes ❑ No If yes, how much per day? _____ For how many years? _____

Do you use alcohol? ❑ Yes ❑ No If yes, how much per week? _____

Are you on a diet? ❑ Yes ❑ No If yes, what type? _____

Mental Health Care (Psychiatric or Psychological)

Date Problem and type of care given

_____

_____

Other Medical Information

Please note any other pertinent information (e.g., use of eyeglasses, contact lenses, dentures, etc.) that you feel would be essential to Student Health Services to ensure that you receive complete medical care while at HHCI.

_____

_____

I hereby state that to the best of my knowledge, my answers to the above questions are correct.

_____

Student's Signature Medical Provider's Signature Date

Medical History / Physical Exam *(page 3 of 3)*

Note: All items must be completed

Patient's Name: Date of Birth:

Last First Middle Month / Date / Year

Height Weight BP

Laboratory Finding: These tests are required and must be completed:

Date _____ Vision* _____ Color Vision _____

Hct. or Hgb. _____ Without glasses: Right 20 / _____ Left 20 / _____

Urine: Glucose _____ Protein _____ With glasses: Right 20 / _____ Left 20 / _____

Hearing*: Right _____ Left _____

*may be done by your medical office

Check the proper column for each item Enter "N.E." if not evaluated	Normal	Abnormal	Note: Give details of each abnormality. Enter corresponding number before each comment.
1. Head, neck, face, and scalp			
2. Nose and sinuses			
3. Mouth, teeth, gingiva, and throat			
4. Ears - general (canals, drums, etc.)			
5. Eyes - general (lids, pupils, motions, etc.)			
6. Lungs, chest, and breasts			
7. Heart			
8. Vascular system (include varicosities)			
9. Abdomen and viscera (include hernia)			
10. Ano-rectal and pilonidal			
11. Endocrine system			
12. Genito-urinary system			
13. Upper extremities			
14. Lower extremities			
15. Spine, other musculoskeletal			
16. Skin and lymphatic (include acne)			
17. Neurological system			
18. If female, give menstrual history; specify medication.			

Is student cleared for full participation in all healthcare training activities? ❑ Yes ❑ No

If no:

Any history of emotional illness or eating disorders? ❑ Yes ❑ No

Present ❑ Yes ❑ No

Past ❑ Yes ❑ No

Are there special medical instructions for HHCI while the student is in school? ❑ Yes ❑ No

If yes, provide details on reverse or on separate sheet.

Medical Provider Signature

Please print or stamp

Name

Address

Telephone

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IMMUNIZATION RECORD FORM

Please type or print clearly.

Name:_____ SS#_____
Last First Middle

Street:_____
Number and Street City State Zip Code

Email:_____ Phone:_____

1. **Documentation of Immunity to Chicken Pox, Rubeola (Measles), Mumps and Rubella**

Chicken Pox: (Varicella) Two varicella vaccines at least 4 weeks apart or positive serology or history of health provider diagnosed Varicella. (Titre ratio is required for those with only one recorded vaccine.)
Rubeola: Two measles containing vaccines with at least 1 dose after 1980 or positive serology or history of healthcare provider diagnosed measles.
Mumps: Two mumps containing vaccines or positive serology or history of healthcare provider diagnosed mumps.
Rubella: Two rubella containing vaccines or positive serology.

DISEASE*	DATE OF IMMUNIZATION			TITRE RATIO AND DATE		DOCUMENTATION OF DISEASE BY MD OR NP
	1st	2nd				
Chicken Pox			OR		OR	
Rubeola (Regular Measles)						
Mumps						
Rubella						

*Documented history of disease or immunization or titre ratio is required for chicken pox, rubeola, and mumps if born after 1957.

2. **Evidence of Absence of Tuberculosis.** Please submit documentation of one of the following:

- A negative Mantoux test within the last 12 months.
- If a previous Mantoux was done 12 to 24 months ago, a new test is required. Please provide record of both tests.
- If no previous test has been done, or was done more than 24 months prior, a two Step Mantoux Test is **required**.

Note:*Neither pregnancy nor Bacille Calmette-Guerin (BCG) vaccine are considered exclusions for tuberculin skin test requirement.*

	Date Administered	Date Read	Results	Read By
(within 12 months)				
(2nd step if required)				
(12 -24 months ago)				
A positive Mantoux test requires a clear chest X-ray within the last 5 years and an evaluation by a physician to certify that you do not have communicable TB within the last 12 months. Chest X-ray date: Results:				

3. **Evidence of Hepatitis B Immunization** (3 dose series: 1st month, 2nd month, 6th month)

Step #1 Date:	Step #2 Date:	Step #3 Date:
Previous immunization without documentation requires titre. Titre recommended after completion of series Titre Date: Results:		

4. **Evidence of Tetanus/Diphtheria Immunization Within Last 10 Years.**

Date of Immunization:

I understand that HHCI will share this information with appropriate faculty, clinical agencies or in the event of an emergency.

_____

Signature of Physician/Nurse Practitioner completing form **Date**