Franklin Pierce University

HEALTH FORMS
p (603) 899-4130
f (603) 899-1050
healthservices@franklinpierce.edu

All students are required to complete and return a Health History, Immunization Record, and Physical forms. ***FORMS DUE: JULY 18**

☐ **STUDENT TO COMPLETE & SIGN HEALTH HISTORY PAGES 1–4. PROVIDER TO COMPLETE & SIGN PAGES 5–6.**

Name: _____ (_____)
LAST FIRST MIDDLE PREFERRED NAME

Previously Used Names: _____

Date of Birth: ____/____/____ Sex: ☐ Male ☐ Female ☐ Intersex ☐ Choose not to disclose Transgender ☐ Woman/Female ☐ Man/Male
MONTH/ DAY/ YEAR

Birth Gender: ☐ Male ☐ Female ☐ Transgender Woman/Female ☐ Transgender Man/Male ☐ Other gender, please specify _____
☐ Preferred Pronouns _____ ☐ Choose not to disclose

Permanent Address: _____
STREET ADDRESS CITY STATE ZIP

Birthplace (Country): _____ Citizenship (if other than U.S.): _____

Home Telephone: ( ) _____ Student Mobile Phone: ( ) _____

Email: _____ Date entering Franklin Pierce: _____

If transferring, indicate college(s) attended (with dates): _____

Emergency Contact: I give permission to Health Services to release information to the people below in case of a medical emergency:

Name: _____ Relationship: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____

Name: _____ Relationship: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____

CONSENT FOR EMERGENCY CARE

To be signed by student **upon reaching their 18th birthday.** (If you are not 18, you must report to Health Services and sign this form when you turn 18). In the event of an emergency, I hereby give permission to Health Services and its affiliated hospital to secure for me appropriate treatment, if necessary, and the release of insurance information for billing purposes.

Student Signature: _____

Date: _____

****Signature BELOW by parent, guardian, or health care proxy agent; mandatory if student is under the age of 18.**

Printed Name: _____

Relationship: _____

Signature: _____

Date: _____

HEALTH INSURANCE INFORMATION

Insurance Company: _____

Insurance Co. Address: _____

_____

Insurance Co. Telephone: _____

Policy ID No.: _____

Group No.: _____

Policy Holder & Relationship: _____

_____

☐ I have reviewed all of the information contained in this Health Form. It is true and accurate to the best of my knowledge.

_____ _____
STUDENT SIGNATURE **DATE**

_____ _____
PARENT SIGNATURE (REQUIRED IF STUDENT IS UNDER 18) **DATE**

Complete and return by July 18.

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Personal History

1. Names and dosages of prescription drugs and herbal/sports supplements: _____
2. Names of over-the-counter medicines used: _____
3. Serious illness/surgery/handicaps: _____
4. Is there anything else Health Services should know about your medial history? _____

Allergies	Yes	No	Surgeries	Yes	No	For women only	Yes	No
Penicillin			Appendectomy			Irregular Periods		
Sulfa Drugs			Tonsillectomy			Severe Cramps		
Other Drugs			Hernia Repair			Excessive Flow		
Chicken Feathers/Eggs			Fractures/Orthopedics			Breast Lumps		
Horse Serum			Handicaps/Special Needs			Other (explain)		
Foods			Other (explain)					
Wasps/Bees								
Trees/Plants								
Dust/Molds			Other (explain)			Medications Used:		
Other (explain)								

Do you have a present or past history of:	Yes	No	EXPLANATIONS: Please explain any answers in the "yes" column (reference item numbers).
1. Alcoholism or Drug Abuse			
2. Anemia			
3. Anxiety, frequent worry			
4. Anorexia/Bulimia			
5. Asthma			
6. Back Problems			
7. Bleeding, abnormal			
8. Blindness/Visual Impairment/Contacts/Glasses			
9. Cancer or impaired immunity			
10. Chicken Pox			
11. Chronic Constipation/Colitis/Diarrhea			
12. Convulsions/Seizure Disorder/Epilepsy			
13. Depression, frequent			
14. Diabetes			
15. Ear Trouble/Hearing Loss/Deafness			
16. Headaches/Migraines - Type			
17. Heart Problems			
18. Hepatitis - Type (_____)			
19. High Blood Pressure			
20. Kidney Disease			
21. Mononucleosis			
22. Pregnancy			
23. Sexually Transmitted Disease			
24. Skin Trouble			
25. Substance Abuse			
26. Thyroid Disorder			
27. Urinary Tract Infection, frequent			
28. Special Needs			
29. Do you smoke or use tobacco? Amount _____ Frequency _____			

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Personal History (continued)

1. If you drink alcoholic beverages, how many per day or week? _____
2. Do you use street drugs, if so what type? _____
3. Do you exercise: Activity level: ☐ Low ☐ Moderate ☐ Strenuous If yes, type: _____
4. Have you had mental health counseling? Is so, when and how long? _____

_____

5. Do you consider yourself to be in: ☐ good ☐ fair ☐ poor health?

Family Medical History

Family Member	Age	State of Health	Occupation	Age at Death	Cause of Death
Father					
Mother					
Brothers/Sisters					
Stepbrothers/Sisters					

Father's Name: _____ Phone No.: _____

Address: _____

Mother's Name: _____ Phone No.: _____

Address: _____

Other's Name & Relationship: _____ Phone No.: _____

Address: _____

Do any immediate members of your family have the following?	Yes	No	Relationship	EXPLANATIONS: Please explain any answers in the "yes" column (reference item numbers).
1. Alcoholism or Drug Abuse				
2. Allergies				
3. Asthma				
4. Convulsions/Seizures				
5. Depression				
6. Diabetes				
7. Headaches/Migraines				
8. Heart Disease				
9. High Blood Pressure				
10. High Cholesterol				
11. Kidney Disease				
12. Lung Disease/TB				

☐ **I have reviewed all of the information contained in this Health Form. It is true and accurate to the best of my knowledge.**

_____ _____
STUDENT SIGNATURE DATE

_____ _____
PARENT SIGNATURE (REQUIRED IF STUDENT IS UNDER 18) DATE

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151:21 Patient Bill of Rights

The policy describing the rights and responsibilities of each patient admitted to a facility, except those admitted by a home health care 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 health care provider of his or her medical condition, health care 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 "health care provider'' means any person, corporation, facility, or institution either licensed by this state or otherwise lawfully providing health care services, including, but not limited to, a physician, hospital or other health care 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 health care 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. 2019, 332:6, eff. Oct. 15, 2019. 2020, 39:61, 62, eff. Jan. 1, 2021.

☐ **I have reviewed all of the information contained in the New Hampshire statute 151:21 Patient Bill of Rights.**

STUDENT SIGNATURE _____ DATE _____

PARENT SIGNATURE (REQUIRED IF STUDENT IS UNDER 18) _____ DATE _____

Complete and return by July 18.

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Physical Form
Physical Examination to be completed by MD/NP/PA/DO. DUE: JULY 15

☐ MD/NP/PA OR DO TO COMPLETE & SIGN THIS PAGE.

To the examiner: Please complete the Physical Examination below and comment on all pertinent findings and be sure all information is complete.

Name: _____ Date of Birth: _____/_____/_____

☐ Male ☐ Female ☐ Sex assigned at birth ☐ Transgender ☐ Non-Binary ☐ Choose not to disclose

Race: _____ Ethnicity: _____

Participating in an intercollegiate sport? ☐ Yes ☐ No (if yes, which sport?) _____

Height: _____ Weight: _____ BP: _____ Pulse: _____ Respirations: _____

Vision: With/ Without glasses: Right 20/_____ Left 20/_____

Hearing: Right Normal ☐ Yes ☐ No Left Normal ☐ Yes ☐ No Hearing Aid? ☐ Yes ☐ No

List all current medications: _____

List all ALLERGIES to food, medications, or other: _____

No.	System	WNL	Abn	Briefly describe abnormality
1.	Skin	☐	☐	
2.	Eyes	☐	☐	
3.	Ears	☐	☐	
4.	Nose, throat	☐	☐	
5.	Neck, thyroid	☐	☐	
6.	Lymphatics	☐	☐	
7.	Chest, Breasts, Lungs	☐	☐	
8.	Heart, rate/rhythm/sounds	☐	☐	
9.	Abdomen	☐	☐	
10.	Genitalia, Rectal	☐	☐	
11.	Extremities, back, spine	☐	☐	
12.	Neurological	☐	☐	
13.	Psychological	☐	☐	

The applicant is in ☐ excellent ☐ good ☐ poor health.

The following abnormalities should be noted: _____

* Targeted TB Skin Testing: ☐ Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors):
Date of PPD: ___; Results: __mm. ☐ Low risk (no PPD done)

REQUIRED! **Provider Contact Information:**

Print Name: _____ **MD/NP/PA/DO**

_____
STREET ADDRESS CITY STATE ZIP

Office Phone: ( ) _____ Fax: ( ) _____

_____ _____
PROVIDER SIGNATURE **DATE OF EXAM**

Complete and return by July 18.

FranklinPierce UNIVERSITY

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Immunization Form

Immunization Form must be completed by MD/NP/PA/DO. DUE: JULY 15

☐ **MD/NP/PA OR DO TO COMPLETE & SIGN THIS PAGE.**

Name: _____ Date of Birth: _____
LAST FIRST MIDDLE

Address: _____
STREET ADDRESS CITY STATE ZIP

Required Immunizations	Date	Date	Titer / Date
1. M.M.R. (Measles, Mumps, Rubella) Two doses measles required. Dose #2 given at least one month after first dose OR report of positive immune titer			
2. Tetanus-Diphtheria: Required Primary Completed Series **Booster within the last 10 years**	Td	Tdap	
3. Varicella	Date	Date	Disease/Date
4. Meningococcal Quadrivalent conjugate (MenACWY) required for all students living in residence halls. **If initial dose given under age 16 yrs. a conjugate booster dose required at >16-21 yrs.**	Quadrivalent Conjugate #1/Date	Quadrivalen Conjugate #2/Date	
5. COVID Immunization (specify brand names)	Date	Date	

6. *** Tuberculosis Screening (within one year of acceptance to Franklin Pierce University)**

a) Have you been in contact with a person who has TB? ☐ Yes ☐ No
b) Do you have signs or symptoms of active tuberculosis diseases? ☐ Yes ☐ No
c) Were you born in another country and arrived in the past 5 years? ☐ Yes ☐ No
d) Are you a member of a high-risk group? ☐ Yes ☐ No

If NO, stop here. If YES, place Tuberculin Skin Test (Mantoux only)
A history of BCG vaccination should not preclude testing a member of a high-risk group.

	Date given	Date read	Result
e) Tuberculin Skin Test *Record of actual MM of induration transverse diameter, if no duration, write "0"*			
f) **Chest QUANTIFRON (required if tuberculin skin test is positive)**	Result: Normal ☐	Result: Abnormal ☐	Date of X-Ray:

Strongly Recommended			
1. **Meningitis B** (two or three doses depending on brand)	Vaccine/Date		
2. Hepatitis B (three doses of vaccine or Pos. Hep B surface antibody).	#1 Date:	#2 Date:	#3 Date:

_____ _____
MEDICAL PROVIDER SIGNATURE **DATE**

Complete and return by July 18.

FranklinPierce UNIVERSITY

Health Services
Counseling and Outreach
Student Accessibility Services

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

Date _____

STUDENT. In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA) my records, conversations, diagnoses, and treatment are confidential and cannot be released until I grant written permission to **Health Services, Counseling, and Student Accessibility Services.**

Students' Name: _____

Date of Birth: _____Student ID# _____Campus PO Box _____

Home Address _____

Cell Phone _____ Email _____

AUTHORIZATION. I authorize **Health Services, Counseling, and Student Accessibility Services** to disclose the following:

- My medical-related information.
- My counseling-related information.
- My student accessibility-related information.

PURPOSE. The reason for this authorization is: (check one)

☐ – To share information as it pertains to my accommodations, treatment and/or medications.
☐ - Information pertaining to my mental health or request for accommodations is the only information to be shared and not the content of therapeutic sessions nor my general health care treatment.
☐ - Other: _____

TERMINATION. This authorization remains active for the entirety of my attendance at Franklin Pierce University.

ACKNOWLEDGEMENT OF RIGHTS. I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission.
I understand that uses and disclosures already made based upon my original permission cannot be taken back.
I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Student _____ Date _____

IF THE STUDENT IS UNABLE TO SIGN DUE TO: (check one)

☐ - **Being a Minor**. Patient is _____ years old and considered a minor under state law.

☐ - **Being Incapacitated**. Patient is incapacitated due to: _____

☐ - **Other**: _____

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Guardian ☐ Other: _____

Signature of Representative:_____

Print Name _____ Date _____

Complete and return by July 18.