

Welcome!

We are very excited that your child is joining our NCC family and we want you to know that all of us involved with the NCC Health Centre are here to support your child at any time. The Health Centre is run by a team of healthcare professionals including a Nurse Practitioner, Registered Nurse, counsellors, and office administration. This health initiative will provide students with access to more immediate health care as the need arises. In the case of an emergency, students will be sent to the closest Emergency Department at our local hospital.

Please note that over-the-counter medications, prescription medications and all herbal pills are **not allowed** in student's rooms. All medication will be kept in the Health Centre. Exceptions to this are asthma inhalers and EpiPens.

It is mandatory that you provide us with the following health information which will allow us to provide the best possible care for your child.

COMPULSORY HEALTH FORMS TO BE PROVIDED TO NCC

Medical History Profile & COVID-19 Questionnaire

**To be completed EVERY year*

Medication Treatment Plan Consent

**To be completed EVERY year*

Immunization History

To be completed on 1st year of enrollment - updates added annually

Physical Examination by a Primary Care Provider (physician / nurse practitioner)

To be completed on 1st year of enrollment

*** DO NOT send non-prescription medications with your child *
as they are not permitted to be kept in dorm rooms.**

HOW TO SUBMIT (3 OPTIONS)

- Scan and email forms to healthcenter@niagaracc.com
- Mail or courier forms to NCC prior to August 14, 2023.
- Send forms via fax to: **(country code)-1-905-871-9260**

*** FAILURE TO SUBMIT FORMS WILL DELAY CLASS START**

RISK ASSESSMENT

Has your student...	Used Alcohol?	Y	N	Used Drugs?	Y	N	Smoked/Vaped?	Y	N
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MENTAL HEALTH

Has your student...	Expressed depression symptoms?	Y	N	Displayed anxiety symptoms? (worrying/nervousness)	Y	N
	Been treated for a mental illness?	Y	N	Taken medications for mental illness?	Y	N
	Had suicidal/homicidal ideation?	Y	N	Had self-harm behaviour (eg. cutting)?	Y	N
	Had a previous suicidal attempt?	Y	N	Struggled with eating/weight challenges?	Y	N

FAMILY HISTORY

	Age	State of Health	Occupation	Age of Death	Cause of Death	Any additional family health history?
Father						
Mother						
Brother(s)						
Sister(s)						

Please provide any additional health information on a separate page

COVID-19 QUESTIONNAIRE

- Has the student had COVID-19 infection(s)? **Yes** **No**
If so, when? (month/year) _____
- Is your student aware of their previous infection? **Yes** **No**
- Has your student experienced any residual health effects from a previous COVID-19 infection? **Yes** **No** **N/A**
If so, please describe: _____
- Has your student received an approved COVID-19 vaccine? **Yes** **No**
If yes, which one and when?
1st (Date): _____ **Vaccine Name:** _____
2nd (Date): _____ **Vaccine Name:** _____
3rd (Date): _____ **Vaccine Name:** _____

Please note: Any information provided allows staff to make informed decisions while following provincial guidelines in order to keep our campus healthy with minimal disruption to students and staff.

Student's Signature Date

Parent's Signature Date



NCC HEALTH CENTRE MEDICATION TREATMENT PLAN CONSENT

Dear Parents/Guardians of _____(full student name)

It is NCC's policy to require parents/guardians to complete and sign the Medical Treatment Plan Consent.

Prescription Medication Consent

Please list all prescription medications the student is receiving and attach a letter or prescription from the prescription provider.

Health Canada allows travelers to bring a single course of treatment or a 90-day supply of medication into the country.

If the medication is required for a longer duration of time, the student will be seen in our Health Centre and a new prescription can be prescribed in compliance with the Province of Ontario medication standards.

PLEASE NOTE: All medications must be labeled with name of student, name of medications, dosage, route, frequency and name of prescribing provider.

Medication	Dose	Route	Frequency
1.			
2.			
3.			
4.			
5.			

PLEASE ATTACH A COPY OF THE ORIGINAL PRESCRIPTIONS

I give permission for the NCC Health Center and Dorm Staff to give the following prescribed medications listed above to the student.

_____ Guardian Signature

_____ Date



NCC HEALTH CENTRE MEDICATION TREATMENT PLAN CONSENT

Non-Prescription (Over The Counter) Medication Consent

I give permission to the NCC Health Center Nursing Staff and to Dorm Staff to administer non-prescription over the counter medications to my child for minor ailments and complaints (such as minor allergies, minor pain, coughs, colds and fevers) according to guidelines approved by the Nurse Practitioner.

_____ Guardian Signature _____ Date

Student Agreement For All Medications: Prescribed and Non-Prescribed

1. I understand that I am responsible for taking medications as directed.
2. I will provide all medications to the NCC Health Center Staff
3. I agree to contact an adult on campus if I don't feel well or if I have a question about my medication.
4. I agree never to share my medication with anyone.
5. I agree NOT to keep medications in my dorm room or on my person unless authorized to do so by the NCC Health Center.
6. I understand that not following these guidelines may result in Disciplinary Action.

_____ Parent Signature _____ Date

_____ Student Signature _____ Date

It is the responsibility of the Physician/Parent/Guardian to advise the NCC Health Center of any changes to the medications or medication treatment plan. The NCC Health Clinic will not deviate from the original medication treatment plan without this consent.

If you have any questions or concerns, please contact Carmel Van Brussel, Office Manager, NCC Health Center.

Sincerely,

Carmel Van Brussel

Office Manager

MEDICATIONS

Please note that over-the-counter medications, prescription medications, and all herbal medicines are **NOT ALLOWED** in student's rooms without Health Centre approval. All medication will be kept in the Health Centre and dispensed as required. Exceptions to this are asthma inhalers and EpiPens.

Failure to comply will result in disciplinary action.



NCC HEALTH CENTRE IMMUNIZATION HISTORY

Name: _____

Date-of-birth: _____

Immunization	DD/MM/YY	DD/MM/YY	DD/MM/YY	DD/MM/YY	DD/MM/YY	DD/MM/YY
	2 months	4 months	6 months	18 months	4 – 6 years	14 – 16 years
Diphtheria-Pertussis-Tetanus (Tdap)	/ /	/ /	/ /	/ /	/ /	/ /
	2 months	4 months	6 months	18 months	4 – 6 years	
Polio (OPV)	/ /	/ /	/ /	/ /	/ /	
	12 months	4-6 years				
Measles-Mumps-Rubella (MMR)	/ /	/ /				
	12-13 years					
Hepatitis B (Hep B) (Grade 7)	/ /					
	12 months	12-13 years				
Meningococcal	/ /	/ /				
	15 months	4-6 years				
Varicella Chickenpox	/ /	/ /				
	Dose 1	Dose 2	Dose 3 (if needed)			
Human Papillomavirus (HPV) (grade 7) recommended	/ /	/ /				
	Dose 1	Dose 2	Dose 3			
COVID-19 Vaccine (recommended)	/ /	/ /	/ /			
	Brand:	Brand:	Brand:			

The above vaccines are mandatory for students in Ontario schools (unless specified). Please have your Primary Care Provider administer missing doses prior to arrival. **Niagara Region Public Health reviews all student immunization records to reconcile missing vaccinations.**



**NCC HEALTH CENTRE
IMMUNIZATION HISTORY**



General Statement of Health

Please complete this general assessment, as well as a pre-participation physical, and attach any applicable treatment plans for pre-existing conditions and concerns. Thank you.

Name: _____ Date of Birth: _____
 Height: _____ cm Weight: _____ kg Allergies: _____
 Blood Pressure: Standing: _____/_____ Sitting: _____/_____
 Vision: Right: 20/_____ Left 20/_____ Corrected: Yes _____ No _____

Medical	Normal	Abnormal
1. Appearance:		
- Marfan Stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, aortic insufficiency)		
2. Eyes/ears/nose/throat:		
- Pupils		
- Hearing		
3. Lymph nodes:		
- enlargement		
4. Heart:		
Murmurs, Location of point of maximal impulse Auscultation standing and supine: Normal _____ Abnormal _____		
5. Pulses:		
- Simultaneous femoral and radial pulses: Yes _____ No _____		
6. Lungs		
- adventitious sounds, shortness of breath		
7. Abdomen:		
- pain, bowel movements, nausea		
-		
8. Genitourinary (males – testicles)		
- frequent UTIs		
9. Skin		
- HSV, lesions suggestive of MRSA, tinea corporis		
10. Neurologic:		
- migraines		
11. Musculoskeletal:		
- Neck, back (scoliosis), shoulder/arm (0-180 degree abduction), elbow/forearm, wrist/hand/fingers, hip/thigh, knees, leg/ankle, foot/toes, functional (duck-walk, single leg hop)		



Cleared for all sports without restrictions: Yes _____ No _____

Cleared for all sports without restrictions with recommendations for further evaluation or treatment for:

Not cleared for sports.
Pending further evaluation: _____
For any sports: _____
For certain sports: _____
Reason: _____
Recommendations: _____

Consider the following questions:

- Has the student felt stressed or under a lot of pressure? _____
- Has the student felt sad, hopeless, depressed, or anxious? _____
- Does the student have any/or has had any suicidal/homicidal ideations? _____
- Has the student previously attempted suicide? _____
- Has the student had any self-harm behaviours (eg. cutting)? _____
- Does the student feel safe at their home or residence? _____
- Does the student use cigarettes, chewing tobacco, snuff, or dip? _____
- Does the student drink alcohol or use any other drugs? _____
- Does the student use anabolic steroids or any other performance supplement? _____
- Does the student take any supplements to help them gain or lose weight or improve their performance? _____

Were further tests indicated based on your examination?

Urinalysis: No _____ Yes _____ Results: _____
Hemoglobin: No _____ Yes _____ Results: _____
ECG: No _____ Yes _____ Results: _____
TB Skin Test: No _____ Yes _____ Results: _____
Other Tests: _____

Does the student require an Adacel (Diphtheria/Tetanus/Pertussis booster required at age 14) immunization?
No _____ Yes _____ Date administered _____

I have examined _____ and completed the preparticipation physical evaluation. The student does not present apparent clinical contraindications to practice and participate in the sport program at NCC. If conditions arise after the student has been cleared for participation, the physician may rescind the clearance until the program is resolved and the potential consequences are completely explained to the student (and parents/guardians). I certify this patient is fully immunized to the standards set by the Ontario Ministry of Health.

Name of Primary Care Provider (print): _____
Address: _____
Phone: _____ **Fax:** _____

Primary Care Provider's Signature

Date

NOTE: Applicant is responsible for costs of physical examination and form completion.