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 medicines 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 children.

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*
	Physical Examination by a Primary Care Provider - physician or nurse practitioner *To be completed on 1st year of enrollment*
*** <u>Do not</u> send over-the-counter 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 15, 2022.
- Send forms via fax to: **(country code)-1-905-871-9260**

<u>* FAILURE TO SUBMIT FORMS WILL DELAY CLASS START</u>

NIAGARA CHRISTIAN COLLEGIATE

MEDICAL HISTORY PROFILE

Name of Student: _____ Date of Birth: _____ Gender: _____

Emergency Contact *(Name, Relationship, and Address)*:_____

_____

Chronic Medical Problem List	Date of Diagnosis	Past Surgical History	Date
Allergies (including environmental)		**Hospitalizations**	**Date**

Health Alerts

Anaphylaxis		Yes	**Epilepsy**		Yes	**Diabetes** (type I or II)		Yes	**Asthma**		Yes
		No			No			No			No

PERSONAL HISTORY: Please Answer All Questions.

Have you had?	Y	N		Y	N		Y	N		Y	N
Scarlet Fever			Insomnia			Pain/Pressure in Chest			Jaundice		
Measles			Recurrent Headaches			Chronic Cough			Gall Bladder Trouble or Gallstones		
German Measles			Recurrent Colds			Palpitations (Heart)			Recurrent Diarrhea		
Mumps			Head Injury/Concussion			High Blood Pressure			Recent Gain or Loss of Weight		
Chicken Pox			Tuberculosis			Low Blood Pressure			Dizziness, Fainting		
Malaria			Shortness of Breath			Rheumatic Fever			Weakness, Paralysis		
Gum or Tooth Trouble			Hay Fever/Seasonal Allergies			Heart Murmurs			Venereal Disease		
Sinusitis			**Allergy to Medications**	**Y**	**N**	Disease/Injury of Joints			Frequent Urination		
Eye Trouble			• Cephalosporins			Bulimia					
Ear, Nose, Throat Surgery			• Fluroquinolines			Anorexia					
Appendectomy			• Macrolides			Back Problems					
Tonsillectomy			• Penicillin			Tumor, Cancer, Cyst			**FEMALES ONLY**	**Y**	**N**
Hernia Repair			• Sulfonamides			Stomach or Intestinal Trouble			Irregular Periods		
Thyroid Disease			• Tetracycline						Severe Cramps		
Food Allergies			• Other Allergies			Regular Fevers			Excessive Flow		

	Y	N		Y	N
Has your physical activity been restricted during the past five years? (Give reasons and durations)			Have you had any illness or injury or been hospitalized other than already noted? (Give Details)		
Have you had difficulty with school, studies, and teachers? (Give Details)			Have you had a psycho-educational assessment (If so, please attach a copy).		
Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem? (Give Details)			Have you consulted or been treated by clinics, physicians, healers, or other specialists within the past five years? (Other than routine checkups?)		

RISK ASSESSMENT

Has your student…	Used Alcohol?	Y	N	Used Drugs?	Y	N	Smoked/Vaped?	Y	N

NIAGARA CHRISTIAN COLLEGIATE

MEDICAL HISTORY PROFILE

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
Father					
Mother					
Brother(s)					
Sister(s)					

Have any of your relatives ever had any of the following?	Y	N	Relationship
Tuberculosis			
Diabetes			
Kidney Disease			
Arthritis			
Stomach Disease			
Asthma, Hay Fever			
Epilepsy Convulsions			

Please provide any additional health information on a separate page

COVID-19 QUESTIONNAIRE

1. Has the student had COVID-19 infection(s)? **Yes** **No**
   If so, when? (month/year) _____
2. Is your student aware of their previous infection? **Yes** **No**
3. Has your student experienced any residual health effects from a previous COVID-19 infection? **Yes** **No** **N/A**
   If so, please describe: _____
4. 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

NIAGARA CHRISTIAN COLLEGIATE

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 travellers 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 labelled 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

NIAGARA CHRISTIAN COLLEGIATE

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.**

NIAGARA CHRISTIAN COLLEGIATE

IMMUNIZATION HISTORY

Name: _____ Date-of-birth: _____

Gender: _____

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**
DPT Diphtheria-Pertussis-Tetanus (2, 4, 6, 18 months, 4-6, 14-16 years)	/ /	/ /	/ /	/ /	/ /	/ /
	2 months	**4 months**	**6 months**	**18 months**	**4 – 6 years**	
Polio (OPV) (2, 4, 6, 18 months, 4-6 years)	/ /	/ /	/ /	/ /	/ /	
	12 months	**4-6 years**				
MMR Measles-Mumps-Rubella (1 year, 4-6 years)	/ /	/ /				
	12-13 years					
Hepatitis B (Grade 7)	/ /					
	12 months	**12-13 years**				
Meningococcal (1 year, Grade 7)	/ /	/ /				
	15 months	**4-6 years**				
Varicella Chickenpox (15 months, 4-6 years)	/ /	/ /				
	Dose 1	**Dose 2**	**Dose 3**			
COVID-19 Vaccine (recommended)	/ / Brand:	/ / Brand:	/ / Brand:			

The above vaccines are mandatory for students in Ontario schools (COVID-19 vaccine recommended).
If any of these vaccines are missing from your child's record please have your primary care provider update them.

NIAGARA CHRISTIAN COLLEGIATE

PHYSICAL EXAMINATION BY PRIMARY CARE PROVIDER

General Statement of Health

Please include a summary of general assessment, preparticipation physical, chronic diseases, psychological and psychiatric concerns.

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 (kyphoscoloiosis, 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)		

NIAGARA CHRISTIAN COLLEGIATE

PHYSICAL EXAMINATION BY PRIMARY CARE PROVIDER

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 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.