NIAGARA CHRISTIAN COLLEGIATE

NCC HEALTH CENTRE
LOCAL ADMISSIONS PACKAGE
2023 - 24

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, counselors, 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.

The Health Centre recognizes and encourages that local students are followed by their own Primary Care Provider, however, providing this information allows Health Centre staff to provide informed first aid and over-the-counter medication in combination with reaching out to you should the need arise.

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 yearr*
	Immunization History *To be completed on 1st year of enrollment - updates added annually*

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**

NIAGARA CHRISTIAN COLLEGIATE

NCC HEALTH CENTRE
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

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

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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

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.

NIAGARA CHRISTIAN COLLEGIATE

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.**