INDIANA WESLEYAN UNIVERSITY

STUDENT HEALTH CENTER
4201 SOUTH WASHINGTON STREET
MARION, INDIANA 46953-4974
765-677-2206
765-677-2849 FAX

HEALTH FORM

PLEASE MAIL DIRECTLY TO THE HEALTH CENTER

Fall Semester due by August 15th
Spring Semester due January 1st
Summer Semester due May 15th

INSTRUCTIONS

1. **A completed and up-to-date health form is required by IWU**
2. **If this form is not completed and/or absent from the Health Center, a restriction will be placed on the student's registration for the following semester until the form is completed and submitted.**
3. **The required physical is to be performed and signed off by a M.D, N.P., PA-C or D.O. and is to be done within the last 12 months.**

PERSONAL INFORMATION

NAME	DATE OF BIRTH	GENDER	STUDENT ID NUMBER
HOME ADDRESS	CITY	STATE	ZIP CODE
HOME PHONE	CELL PHONE	E-MAIL ADDRESS	
PARENT/GUARDIAN	HOME PHONE	WORK PHONE	
IN CASE OF EMERGENCY (other than parent)	HOME PHONE	WORK PHONE	
ENROLLING AS: (circle one) Fresh Soph Junior Senior	SEMESTER & YEAR ENTERING IWU: (Circle one): Fall Spring Sum of 20_____		
HAVE YOU BEEN PREVIOUSLY ENROLLED AT IWU (circle one) Yes No **If Yes**, What was the last semester you attended IWU? Fall Spring Summer of 20_____			

Do you have health insurance coverage? ☐ Yes ☐ No

FOR INSURANCE TO BE BILLED WE MUST HAVE A PHOTOCOPY OF INSURANCE CARD FRONT AND BACK ATTACHED TO THE HEALTH RECORD.

If yes--- Name of Insured:_____ Date of Birth:_____/_____/_____

CONSENT FOR TREATMENT/FINANCIAL RESPONSIBILITY

- ⇨ I give consent for medical services and procedures, immunizations and TB test, medication and other services as needed at the IWU Health Center.
- ⇨ I have been given the opportunity to review and request a copy of the *Notice of Privacy Practices*.
- ⇨ I have reviewed and understand the accompanying information on meningococcal meningitis. I understand that the Meningococcal meningitis vaccine offers protection against certain strains of Neiserria Meningitis and is recommended for students in residence halls, and that the vaccine is available through family physician offices, clinics, health departments or the IWU Health Center.
- ⇨ I understand that I am responsible for payment in full of all medical services rendered to me by the IWU health Center. I agree to pay any allowable amounts not covered by my insurance, as well as all co-pay and deductible amounts, in a timely manner. Should it become necessary to use other collection methods to satisfy my account I understand that I am responsible for any amount necessary to obtain payment on my account, including attorney fees and court costs.

Student's Signature:_____ Date:_____

Parent/Guardian Signature:_____Date:_____
(MUST be signed by parent if student is under 18)

⇨ I authorize the release of medical information to my parent(s) or legal guardian as deemed necessary by the Health Center Staff for medical treatment and follow-up care.

Student's Signature:_____ Date:_____

Name:_____ Date of Birth _____/_____/_____

PERSONAL HEALTH HISTORY

(This information is strictly confidential for the use of the Health Clinic and will not be released to anyone without your knowledge and written consent or as required by law)

Check if you have ever had or currently have any of the following.

	√	Date/Comments		√	Date/Comments
ADD/ADHD			Head Injury		
Alcohol/Substance Abuse			Heat Cramp/Heat Illness		
Anemia			Hepatitis		
Asthma			High Blood Pressure		
Bone, joint, or other deformity			Immune Disorder		
Cancer			Kidney Disease		
Chest Pain			Meningitis		
Concussion			Mononucleosis		
Depression or Anxiety			Migraine/Frequent Headache		
Diabetes			Pneumonia		
Ear, Nose, Throat Trouble			Shortness of Breath		
Eating Disorder			Stomach/Colon Problems		
Epilepsy/Seizure Disorder			Thyroid Disorders		
Fainting/Dizziness			TB Disease or Positive TB Test		
Heart Disease/Heart Murmur			Other		

OTHER INFORMATION

List any allergies you have (environmental, food, medication, other)

Do you take allergy desensitization shots? ☐ Yes ☐ No If yes, how often?

Surgeries/Hospitalizations: (Please indicate Month/Year for each)

Current Medical Problems

Routine Medications Taken:

During or after physical activity- do you have chest pain, trouble breathing or do you cough? ☐ Yes ☐ No
Have you ever passed out? ☐ Yes ☐ No
Have you ever been dizzy? ☐ Yes ☐ No

Do you have any physical disability ☐ visual ☐ hearing ☐ other_____
Do you use any special equipment in connection with the above?

Is there any other information that would be helpful for the Health Center to know?

TB SCREENING: Please complete the following Risk Assessment Questions

☐ Yes ☐ No Have you had any of the following symptoms?
- unexplained cough of more than 3 weeks of bloody sputum
- unexplained night sweats, weight loss or fever

☐ Yes ☐ No Do you have any of the following risk factors to TB infection?
- cancer or long term immunosuppressive therapy
- close contact with an active TB patient
- use of illegal drugs
- HIV infections or AIDS
- Recent resident or employee of correctional facility, nursing home, homeless shelter or health care setting

☐ Yes ☐ No Have you traveled or lived outside the United States to any country **NOT** on the following list:

American Regions:	Canada	Jamaica	Saint Kitts and Nevis	Saint Lucia
	USA	Virgin Islands (USA)		
European Region:	Belgium	Denmark	Finland	Germany
	Greece	Iceland	Ireland	Italy
	Liechtenstein	Malta	Monaco	Netherlands
	Norway	San Marino	Switzerland	United Kingdom
Western Pacific Regions:	American Samoa	Australia	New Zealand	

If you answered yes to any of the questions above, you MUST have a TB Skin Test administered in the United States within the last twelve months.

Name:_____ Date of Birth _____/_____/_____

PHYSICAL EXAMINATION

TO BE COMPLETED BY PHYSICIAN OR HEALTH CARE PROVIDER AFTER EXAMINATION

Student Name		Date of Birth	
Height	Weight	B/P	Pulse
Vision: R 20/_____	L 20/_____	Corrected: (circle one) Yes or No	Pupils: Equal/Unequal R>L R<L

	NORMAL	ABNORMAL		NORMAL	ABNORMAL
ENT			CARDIOVASCULAR		
LUNGS			GENITOURINARY/HERNIA		
SKIN			NEUROLOGICAL		
ABDOMINAL			OTHER		
MUSCULOSKELETAL			COMMENTS		
COMMENTS:					
Is the student now under treatment of a serious medical condition and or mental health disorder?					

Please attach a copy of patient's current immunization record or see immunization certificate on next page.

TB Test (if indicated by TB Screen on page 2)

Date Administered:_____/_____/_____ Time_____ Date Read: _____/_____/_____ Time_____

Reaction in Millimeters:_____

QuantiFERON-TB Gold Blood Test or T-Spot (if required)

Date Administered: ____/____/____ Results:_____ (attach a copy of report)

(TB test/QuantiFERON-TB Gold Blood Test available at IWU Health Center)

If positive mantoux PPD skin test in past: Date:_____

Chest x-ray report must be attached to health History Form and follow-up records by Health care professional attached.

Signature of Health Care Provider_____ Date:_____

Practitioner's Name_____ Phone_____

(please print)

Practitioner's Signature_____ Date_____

Name:_____ Date of Birth _____/_____/_____

IMMUNIZATION CERTIFICATE

Attach a copy of your immunization records from your doctor, high school or Health Department **OR** have a health care provider complete this form and return it to you.

****Please read carefully as you may need a booster dose to meet requirements****

REQUIRED IMMUNIZATIONS				
Immunization	Date of Immunization			
M.M.R (MEASLES, MUMPS, RUBELLA) *Two doses required* 1. Dose 1, given at age 12-15 months or later 2. Dose 2, given at age 4-6 yrs or later, and at least one month after 1st dose.	#1____/____/____ (12-15mos)	#2____/___/____ (4-6 years)		
TETANUS, DIPTHERIA, PERTUSSIS *Primary series with DtaP or DTP and Booster with Td or Tdap given within the last 10 years meets requirement*	Primary Series completed; Yes_____ No_____		Booster within last 10 years; Td ___/___/___ or Tdap ____/____/___	
RECOMMENDED IMMUNIZATIONS				
POLIO: *Primary series in childhood meets requirement*	#1____/____/____ IPV/OPV	#2____/____/____ IPV/OPV	#3____/____/____ IPV/OPV	#4____/____/____ IPV/OPV
VARICELLA *History of chicken pox, Positive Varicella antibody or two doses given at least one month apart after age 13 yrs. Meet requirement* *1.* History of disease ☐ Yes ☐ No *2.* Immunization: Dose 1 and Dose 2 (given at least one month after first dose, if 13 yrs+) *3.* Varicella Antibody	#1____/____/____	#2____/____/____	Titer Results_____ Date:_____	
HEPATITIS B *Three doses or positive surface antibody meets requirement.* 1.Immunization 2.Hepatitis B surface antibody	#1____/____/____	#2____/____/____	#3____/____/____	Titer Results_____ Date:_____
MENINGOCOCCAL *One dose recommended for college students, particularly freshmen in residence halls. Revaccinate every 5 years if increased risk continues.* ☐ Menomune ☐ Menactra	#1____/____/____			
INFLUENZA Annual immunization recommended for college students	#1____/____/____			
TRAVEL IMMUNIZATIONS				
HEPATITIS A	#1____/____/____	#2____/____/____		
TYPHOID Oral_____ or Injectable_____	#1____/____/____			
YELLOW FEVER	#1____/____/____			
POLIO BOOSTER (IPV)	#1____/____/____			
OTHER	#1____/____/____			
OTHER IMMUNIZATIONS (i.e. Gardasil)				
	#1____/____/____	#2____/____/____	#3____/____/____	#4____/____/____

Signature of Practitioner/Health Department:_____ Date:_____

NOTICE OF MEDICAL PRIVACY PRACTICES

This notice describes how medical information about you may be used or disclosed and how you may access this information. Please review this Notice carefully

The Indiana Wesleyan University Health Center creates an electronic medical record for you as soon as health information is received in our office and it continues through each encounter you may have in the center. This record may contain health history, immunization record, information about your symptoms, examinations, test results, medications, allergies, and a plan for your care as indicated. Your medical record is an essential part of the healthcare we provide for you. It contains personal health information. State and federal law protects the privacy of this information.

We will use your electronic medical record for treatment. All the nurse practitioners, physicians, nurses, clinical staff, and student nurses involved in your care will document in your record details about your physical examination and the care planned for you. We will provide physicians or other healthcare providers who are treating you with information from your medical record that is pertinent to your care. We may also use your medical record to call you or send a reminder about an appointment, to follow up with diagnostic tests results, or to provide you with information about other treatment or care that could benefit your health. Pertinent medical information may also be shared with other Indiana Wesleyan University staff such as Student Development and/or Center for Student Success, if it is deemed necessary to prevent a serious threat to your health and/or safety.

Your electronic medical record may be used or disclosed in connection with other university healthcare operations, including quality assessment and improvement activities, review of the competence or qualifications of healthcare professionals, evaluation of provider performance, accreditation, certification, licensing, and credentialing activities.

Your electronic medical record may be used to notify or assist in the notification of a family member, your personal representative, or another person responsible for your care, of your location, your general condition, or in the event of your death. If you are present and capable, you will be given opportunity to object to the use or disclosure of your medical record prior to such use or disclosure. If you are incapacitated, your medical record will be used or disclosed on the professional judgment of Indiana Wesleyan University personnel. Only relevant information from your medical record will be disclosed to persons involved in your care.

Your electronic medical record may also be disclosed if required by law.

Your electronic medical record may also be used for the purpose of billing you or your third party payor (insurance). The information on or accompanying the bill may include information that identifies you, as well as your diagnoses, procedures, healthcare providers, and supplies used. We also may contact your insurance company to determine if they will pay for your medical care as part of their certification process.

You may provide Indiana Wesleyan University with written authorization to use your medical record or to disclose it to anyone, for any purpose. You may also revoke such authorization in writing at any time. Without your written authorization, your medical record will not be disclosed except as described in this Notice.

Your rights - You have the right to:

1. Request a restriction on certain uses and disclosures of your information: if the university agrees with your request, we will comply unless the information is needed to provide emergency treatment.
2. Obtain a paper copy of this Notice upon request by calling (765) 677-2206.
3. Obtain a copy of your medical record.
4. Request an amendment to your medical record.
5. Obtain an accounting of disclosures of your medical record.
6. Request disclosure of your medical record in a manner and location of your choosing.
7. Revoke your authorization to use or disclose your medical record except to the extent that action has already been taken.
8. File a complaint if you feel your privacy rights have been violated.

   To exercise any of your patient rights, submit a written request to the Student Health Center.

Our responsibilities - Our duties are to

1. Maintain the privacy of your electronic medical record.
2. Provide you with notice of our legal duties and privacy practices regarding your electronic medical record.
3. Abide by the terms of this notice.
4. Notify you if we are unable to agree or comply with to a requested restriction.
5. Accommodate your reasonable requests to disclose your medical record in a manner and location of your choosing.

   We reserve the right to change the terms of this Notice and our privacy policies at any time. Prior to making significant changes to our policies, we will post a notice of such changes in the waiting area of the Student Health Center.

If you believe your privacy rights have been violate, you may submit a written complaint to the Student Health Center or contact the U.S. Department of Health and Human Services. For more information about filing a complaint, visit www.hhs.gov/orc/hippa on the Web. You will not be penalized for filing a complaint.

OVERVIEW OF MENINGOCOCCAL DISEASE

DISEASE INFORMATION

Meningococcal disease is an acute bacterial infection that strikes nearly 1,500 Americans each year. Adolescents and young adults are particularly vulnerable to the disease, accounting for nearly 15 percent of all cases in the U.S. A recent study found 11% who are infected will die, and of those who survive, up to 20 % will experience permanent disability.

Meningococcal disease, although rare, is devastating because early symptoms resemble the flu, making it difficult to recognize. However, unlike the flu, the disease can progress rapidly and within hours of initial symptoms, may cause hearing loss, brain damage, limb amputation and even death. Symptoms include high fever, headache, stiff neck, confusion, nausea, vomiting and exhaustion. In later stages, a rash may appear. Adolescents and young adults should seek medical attention immediately if they notice unusually sudden or severe symptoms of the disease.

The infection usually manifests itself as an inflammation of the membranes around the brain and spinal cord *(meningococcal meningitis*) or an infection of the blood (*meningococcemia*), and they are caused by the same bacteria (*Neisseria meningitides*).

Meningococcal bacteria are transmitted through the air via droplets of respiratory secretions and direct contact with the persons infected with the disease.

MENINGOCOCCAL DISEASE PREVENTIONS

The Centers for Disease Control and Prevention issued recommendations calling for routine vaccination with meningococcal conjugate vaccine for adolescents 11-18 years of age, with the first dose at 11-12 years of age and a booster dose at age 16. If the first dose is given between 13-15 years of age, the booster should be given between 16-18 years old. If the first dose is given at age 16 or older, a booster is not needed. **College freshmen living in dormitories are at a higher risk for meningococcal disease compared to other people of the same age.** Additionally, CDC states all other adolescents and college students wishing to reduce their risk may elect to be immunized if not previously vaccinated. The American Academy of Pediatrics, American Academy of Family Physicians, and the American College Health Association also supports these recommendations.

The Meningococcal Meningitis Vaccine offers protection against certain strains of Neiserria Meningitis. The meningitis vaccine, Menactra, has recently been approved for use among persons aged 11 to 55 years. Menomune is another meningitis vaccine that has been quite effective in reducing the rates of the disease among certain populations. Meningitis vaccines are available through your family physician, clinic, and the IWU Health Center.

Adolescents and young adults also should be aware of other ways to reduce their risk of contracting the disease, including not sharing beverages or utensils, and regular sleeping patterns.

The following are Web sites that provide more information about meningococcal disease and immunization:

- National Meningitis Association, www.nmaus.org
- Centers for Disease Control and Prevention, www.cdc.gov
- American Academy of Family Physicians, www.aafp.org
- National Foundation for Infectious Diseases, www.nfid.org
- Adult Vaccination, http://www.adultvaccination.org