DEPAUW UNIVERSITY
Est. 1837

STUDENT HEALTH RECORD

DEPAUW UNIVERSITY WELLNESS CENTER

P. O. Box 37 ● Greencastle, IN 46135-0037
Phone: 765.658.4555 ● Fax: 765-658-4554 ● www.depauw.edu

2012

1. **Please complete and submit these forms to DePauw Student Health Services by July 1.**
2. **Physical exam is to be completed by a licensed health care provider within six months prior to sports check-in for varsity athletics. Physical exam is optional for other students.**
3. **Failure to submit the complete Student Health Record and provide proof of immunizations may result in cancellation of student's classes.**

PERSONAL INFORMATION: (Please print or type)

Student Name: _____ Sex: ☐ Male ☐ Female
Last name First name Middle name

Date of Birth: _____/_____/_____ Allergies: _____

Medications: _____

Home Address: _____

City: _____ State: _____ Country: _____ Zip Code: _____

Student Cell Phone Number: _____

IN CASE OF EMERGENCY:

Name: _____ Relationship: _____

Phone: _____

Personal Physician:

Name: _____ Phone: _____

Address: _____
Street City State Zip Code

Insurance Information:

Insurance Company: _____ Policy Number: _____

Name of Insured: _____ Phone Number of Insurance Company: _____

Prescription Card: _____ Policy Number: _____

Preferred Pharmacy: _____

We do not file insurance claims. This information is confidential and will be used to assist the student in obtaining medical services not provided by Student Health Services. Receipts are available to you for insurance purposes, to cover any extra charges incurred at Student Health Services.

Student Name: _____
Last name First name Middle name

STATEMENT OF HEALTH

Please list any medications and/or health care concerns, including any ongoing or significant past medical or psychological conditions:

_____

_____

_____

_____

_____

_____

_____

_____

Meningitis Vaccine

Meningococcal meningitis is a rare, but potentially fatal bacterial infection that can result in inflammation of the membranes surrounding the spinal cord and brain as swell as infection directly into the bloodstream. Permanent disabilities can result even if the individual survives the infection. Since students residing in residence halls are at higher risk for contacting this infection, it is recommended that college students be educated about meningococcal meningitis and the benefits of vaccination.

A vaccine is available that protects against most types of bacteria which cause this infection. DePauw Student Health Services can administer this vaccine for a fee which is billed to the student's account, or you may choose vaccination from your family physician prior to arrival at DePauw. We recommend this vaccination although it is not a requirement. Parents and students are welcome to contact our office for more information or consult our Web site at www.depauw.edu/files/resources/hs-web-page---immunization-policy.pdf

DePauw University Treatment, Release of Information, and Confidentiality Agreement

The DePauw Health Services staff is committed to the privacy of student medical records in accordance with Indiana State laws.

I give my permission to health care providers employed by DePauw University to release medical information that may be required to (1) other health care professionals in order to provide appropriate, timely, quality health care for me. Any student seen in the emergency room at Putnam County Hospital will have a copy of their medical record sent to the campus physician for continuity of care.

Permission is hereby granted to the DePauw Student Health Services physician to proceed with needed medical and minor surgical treatment, X-ray and immunizations for the above named student.

Student's Signature: _____ Date: _____

Parent's Signature**: _____ Date: _____

*** Parent signature **required only** for students that enter DePauw University before their 18th birthday.*

Student Name: _____
Last name *First name* *Middle name*

IMMUNIZATIONS: (This form must be completed in its entirety for all required items.)
To be completed by a licensed health care provider.

A. **M.M.R. (Measles, Mumps, Rubella)**: Two doses *required*. #1 _____/_____ (M Y) #2 _____/_____ (M Y)

B. **Teatanus-Diptheria**: Booster *required* within 10 years.
Primary series:
#1 _____/_____ (M Y) #2 _____/_____ (M Y) #3 _____/_____ (M Y) #4 _____/_____ (M Y) #5 _____/_____ (M Y)

Td or Tdap Booster: _____/_____ (M Y)

C. **Tuberculosis (TB) Screening Questionnaire**. Please check all that apply:
☐ Have been in close contact with someone who has TB, or currently have symptoms of acute TB infection.
☐ Have traveled to or was born in a country * that has endemic TB.
☐ Have a chronic medical problem that puts me at risk for TB or other high risk factors*.
* Please see www.cdc.gov for endemic countries and high risk groups.
If you have checked any of the above, you need a TB skin test or serology within six months prior to travel to campus. If you have ever had a positive TB test, you will need a chest x-ray within six months prior to arrival to campus.

Serology: Date _____/_____/_____ (M D Y) Result: _____ OR

TB skin test: Date Placed _____/_____/_____ (M D Y) Date Read _____/_____/_____ (M D Y) Result _____ mm of induration

Please attach a chest x-ray report if TB skin test 10mm or greater, or if serology is positive.

D. **Polio**: At least three doses recommended.
#1 _____/_____ (M Y) #2 _____/_____ (M Y) #3 _____/_____ (M Y) #4 _____/_____ (M Y) #5 _____/_____ (M Y)

E**. Varicella**: Recommended for those without history of active disease.
Antibody: _____/_____ (M Y) ☐Reactive ☐Non-reactive ☐ History of disease Immunization: #1 _____/_____ (M Y) #2 _____/_____ (M Y)

F**. Hepatitis B**: Highly recommended for all students #1 _____/_____ (M Y) #2 _____/_____ (M Y) #3 _____/_____ (M Y)
Hepatitis B surface antibody: _____/_____ (M Y) ☐Reactive ☐Non-reactive

G. **Hepatitis A**: Recommended for travelers #1 _____/_____ (M Y) #2 _____/_____ (M Y)

H. **Meningococcal Meningitis**: Recommended for undergraduates living in residence halls.
Quadrivalent polysaccharide vaccine: _____/_____ (M Y)

I. Other Immunizations: (Please list)
1. _____ Date _____
2. _____ Date _____
3. _____ Date _____

Health Care Provider must sign below or a copy of an official immunization record must be attached.

Name: _____

Signature: _____ Phone: _____

DePauw University Student Health Services

Notice of Privacy Practice

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE
USED AND DISCLOSED AND HOW YOU MAY ACCESS THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR COMMITMENT TO YOUR PRIVACY

DePauw Student Health Services is dedicated to maintaining the privacy of your individual identifiable health information. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your health information. By federal law and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We reserve the right to revise or amend this Notice of Privacy Practices, provided applicable law permits such changes. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. We will post a copy of our current Notice in our office in a visible location at all times, and you may request a copy of our most current notice at any time.

For more information about our privacy practices, or additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCOLSURES OF HEALTH INFORMATION

We use and disclose health information about your treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment or services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare options. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us this authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying and locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency situations, we will disclose health information based on a determination using our professional judgment disclosing only information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing the person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law. For example, to public health or legal authorities charged with preventing or controlling diseases, injury or disability.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may need to disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody or protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use and disclose limited health information in order to contact you with appointment reminders (such as voicemail messages, e-mails, or letters). We may need to contact you to ask you to call us regarding your health care.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, not including psychotherapy notes. You must submit your request in writing. You may obtain a form to request access from our office. We may charge a fee for the costs of copying, mailing, labor, and supplies associated with your request. We may deny your request to inspect and/or copy in limited circumstances: however, you may request a review of our denial.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your healthcare information. We are not required to agree to additional these restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of how payments (if necessary) will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of health and Human Services.

Contact Officer: DePauw Health Service Privacy Officer
Telephone: (765) 658-4555 Fax: (765) 658- 4554 E-mail: healthsrvs@depauw.edu

Address: DePauw University Wellness Center
DePauw Health Services
Hogate Hall, Suite 100
800 S. Locust St.
P.O. Box 37
Greencastle, IN 46135-0037

I acknowledge I have read this Privacy Notice.

_____

Student's Signature Date

I wish to have the following restrictions to the use or disclosure of my health information: _____

_____

We attempted to obtain written acknowledgement of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign ☐ Communications barriers prohibited using the signed Notice

PHYSICAL EXAM:
To be completed by a license health care provider within six months prior to sports check-in for varsity athletes. Physical exam is optional for other students.

Date of exam: _____ Patient name: _____

Vital Signs: Weight _____ lbs Height _____inches Blood Pressure _____/_____
Pulse _____ Respirations _____ Temperature _____
Vision Screen: Right 20/ _____ Left 20/_____ Both 20/_____
Labs (if indicated): _____

	Normal	**Abnormal-explanation**
Eyes		
ENT		
Lymphatics		
Thyroid		
Respiratory		
Cardiovascular		
Abdominal/GI		
Breast		
Pulses		
Hernia		
Neurologic		
Upper extremity		
Lower extremity		
Back		
Strength		
Flexibility		
Dermatologic		
Pap/Pelvic (optional)		

Assessment:

After examining this patient, I find that he/she has a medical condition that needs further evaluation. ☐ Yes ☐ No
List: _____

After examining this patient, I find that he/she has a medical condition that precludes participation in the following activities:
_____

Health Care Provider:

Name: _____

Address: _____
Street City State Zip Code
Signature: _____ Date _____

Return to: DePauw University Wellness Center
DePauw Student Health Services
Hogate Hall, Suite 100 ● 800 S. Locust Street
P.O. Box 37
Greencastle, IN 46135-0037

Email: healthsrvs@depauw.edu ● Web site www.depauw.edu/studentlife/wellness/health-services