Student Health Record

DePauw University Wellness Center
DePauw Health Services • Hogate Hall, Suite 100 • 800 S. Locust Street
P.O. Box 37 • Greencastle, IN 46135-0037
Phone: 765.658.4555 • Fax: 765.658.4554 • www.depauw.edu

It is important for DePauw University to have complete and accurate medical records of all students. Please complete and submit these forms to DePauw Health Services by Aug. 1. **Failure to submit the completed Student Health Record and provide proof of immunization may result in cancellation of the student's classes.**

PERSONAL INFORMATION: (PLEASE PRINT OR TYPE)

Student Name: ______________________________ Date: ____________
Last name First name Middle name

Social Security Number: ______-______-______ Date of Birth: _____/_____/_____ Sex: ☐ Male ☐ Female

Home Address: ______________________________

City: ______________________________ State: ________ Zip Code: ____________

Student Cell Phone Number: ______________ Student E-mail Address: ______________

Name of Parent or Legal Guardian: ______________________________

Address: ______________________________
Street City State Zip Code

Home Phone Number: ______________ Business Phone Number: ______________

In Case of Emergency:

Name: ______________________________ Relationship: ______________

Phone (day): ______________________________ Phone (evening): ______________

Personal Physician:

Name: ______________________________ Degree: ______________

Address: ______________________________
Street City State Zip Code

Phone: ______________________________ Fax: ______________

Insurance Information: (Please provide copy of insurance and prescription cards)***

Insurance Company: ______________________________ Policy Number: ______________

Name of Insured: ______________________________

Address of Insurance Company: ______________________________
Street City State Zip Code

Phone Number of Insurance Company: ______________________________

Prescription Card: ______________________________ Policy Number: ______________

Preferred Pharmacy: ______________________________

Mail-In Prescription Service: ☐ Yes ☐ No Supply needed? (i.e. 3 months) ______________

Phone Number of Prescription Service: ______________________________

***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:

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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 well 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/student/health/immun.asp.

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, and (2) Counseling Services, Putnam County Hospital, Residence Life, Public Safety, Athletics and/or other health providers to which I may be referred for further evaluation and treatment. 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 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.*

Return to: DePauw University Wellness Center
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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. Tetanus-Diphtheria: *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

1. Have you ever been in close contact with anyone who has TB, or do you currently have symptoms of acute TB infection?
   ☐ Yes ☐ No
2. Have you traveled to or were you born in a country* that has endemic TB, and arrived in the past five years to the U.S.?
   ☐ Yes ☐ No
3. Do you have a chronic medical problem that puts you at risk for TB or other high risk factors*?
   ☐ Yes ☐ No

*Please see www.acha.org/info_resources/tb_statement.pdf for endemic countries and high risk groups.

If you checked YES for any of the above, you need a TB skin test within six months prior to travel to campus. If you have ever had a positive TB test, you will need either a chest x-ray or QuantiFERON TB-Gold Test within six months prior to arrival to campus.

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

Please attach a chest x-ray report or QuanitFERON TB-Gold test result if TB skin test 10mm or greater.

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 dormitories/residence halls.

Quadrivalent polysaccharide vaccine: ______/______ (M/Y)

I. Other Immunizations: (Please list)

1. ______________________________ Date ____________
2. ______________________________ Date ____________
3. ______________________________ Date ____________
4. ______________________________ Date ____________

Health Care Provider:

Name: ____

Signature: ______________________________ Phone: ______________________

DePauw University Health Services

Notice of Privacy Practices

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 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 required by law to maintain the confidentiality of health information that identifies you. We also are 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 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 for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for 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 for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. 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 an 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 circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health 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 a 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 disease, injury or disability.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may 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 of 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-mail, 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 health information. We are not required to agree to these additional 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 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 Services 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.

____

Patient'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 obtaining the signed Notice

PHYSICAL EXAM:

To be completed by a licensed health care provider ***within six months prior to arrival on campus****.*

Date: ____________________ Patient name: ____ Sex: ☐ Male ☐ Female

Vital Signs: Weight ________lbs Height ________in. Blood Pressure _______/_______

Pulse ________ Respirations ________ Temperature ________

Vision Screen: Right 20/______ Left 20/______ Both 20/______

Allergies: ________________________________ Current Medications: ____

____

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 is healthy and cleared for all activities that might be required in a college setting. This includes athletic participation. ☐ Yes ☐ No

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: ____ Degree: ______________________

Address: ____
Street City State Zip Code

Signature: ____ Date: ______________________

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