

INDIANA WESLEYAN UNIVERSITY

Student Health Center
4201 S. Washington Street, Marion, IN 46953
Phone (765) 677-2206; Fax (765) 677-2849

HEALTH FORM

PLEASE MAIL DIRECTLY TO THE HEALTH CENTER

Fall Semester Due by the 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	
ADDRESS OF PARENT OR GUARDIAN		CITY	STATE	ZIP CODE
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__ __				

REQUIRED INFORMATION

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 of Insured: _____
Social Security of Insured _____

CONSENT FOR MEDICAL TREATMENT

⇒ 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 read and understand 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 Neisseria Meningitis and is recommended for students in residence halls, and that the vaccine is available through family physician offices or clinics.

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 parents(s) or legal guardian as deemed necessary by the Health Center Staff for medical treatment and follow-up care.

Student's Signature: _____ Date: _____

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 Cramps/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 (For items where there are none, please indicate "none" rather than leaving an item blank.)

<p>1. Drug/Medication Allergies: (Please list all names of drugs/meds)</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <input type="checkbox"/> No known allergies <input type="checkbox"/> Aspirin </div> <div style="width: 30%;"> <input type="checkbox"/> Penicillin <input type="checkbox"/> Codeine </div> <div style="width: 30%;"> <input type="checkbox"/> Sulfa <input type="checkbox"/> Other: _____ </div> </div>
<p>2. Other Allergies: (Please list all other allergies, such as bee stings, etc.)</p>
<p>3. Surgeries/Hospitalizations: (Please indicate Month/Year for each)</p>
<p>4. Chronic Health Problems:</p>
<p>5. Current Medical Problems/Disabilities:</p>
<p>6. Routine Medications Taken:</p>
<p>7. Do you take allergy desensitization shots? <input type="checkbox"/>Yes <input type="checkbox"/>No If yes, how often?</p>
<p>8. During or after physical activity -- do you have chest pain, trouble breathing or do you cough? <input type="checkbox"/>Yes <input type="checkbox"/>No have you every passed out? <input type="checkbox"/>Yes <input type="checkbox"/>No have you ever been dizzy? <input type="checkbox"/>Yes <input type="checkbox"/>No</p>
<p>9. Are you missing -- <input type="checkbox"/>Eye? <input type="checkbox"/>Kidney? <input type="checkbox"/>Testicle (men only)?</p>
<p>10. Do you have any physical disability-- <input type="checkbox"/>Visual? <input type="checkbox"/>Hearing? <input type="checkbox"/>Other: _____? Do you use any special equipment in connection with the above?</p>
<p>11. Is there any other information that would be helpful for the Health Center to know? (Please attach additional information if needed.)</p>

PHYSICAL-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
ENT		
LUNGS		
SKIN		
ABDOMINAL		
CARDIOVASCULAR		
GENITOURINARY/HERNIA		
NEUROLOGICAL		
MUSCULOSKELETAL		
NECK		
SHOULDERS		
ELBOW		
WRISTS		
HANDS		
BACK and SPINE		
KNEES		
ANKLES		
FEET		
OTHER		

<p>Is there loss or serious impaired function of any organ? Comments:</p>
<p>Is the student now under treatment of a serious medical condition? Comments:</p>
<p>Is the student now under treatment for a clinical mental health disorder? Comments:</p>

Physician's Name _____ Phone _____
(please print)

Physician's Signature _____ Date _____

REPORT OF REQUIRED IMMUNIZATIONS

This requirement may be met in one of two ways:

- Have a physician complete this form and return it to you. Then you may return it by mail or deliver it to the Student Health Center.
- You may obtain a copy of your complete immunization record from your high school or Health Department and attach it your physical form.

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

IMMUNIZATION	Date of Immunization			
	MO/YR	MO/YR	MO/YR	MO/YR
A. M.M.R. (MEASLES, MUMPS, RUBELLA) <i>Two doses required.</i> 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 1 st dose.	#1 ___/___ #2 ___/___			
B. TETANUS AND DIPHTHERIA: <i>Primary series with DtaP or DTP and Booster with Td given within the last 10 years meets requirement.</i> 1. Primary series of four doses with DtaP or DTP 2. Tetanus-Diphtheria (Td) Booster given with in the last 10 years	#1 ___/___ #1 ___/___	#2 ___/___	#3 ___/___	#4 ___/___
C. POLIO: <i>Primary series in childhood meets requirement.</i>	#1 ___/___ IPV/OPV	#2 ___/___ IPV/OPV	#3 ___/___ IPV/OPV	#4 ___/___ IPV/OPV
D. VARICELLA: <i>History of chicken pox., positive Varicella antibody, or two doses given at least one month apart after age 13 yrs. meet requirement.</i> 1. History of disease..... <input type="checkbox"/> Yes or <input type="checkbox"/> No 2. Varicella antibody..... <input type="checkbox"/> Reactive or <input type="checkbox"/> Non-Reactive 3. Immunization: Dose 1 and Dose 2 (given at least one month after first dose, if 13 years +)	___/___ #1 ___/___	#2 ___/___		
E. HEPATITIS B: <i>Three doses or positive surface antibody meets requirement.</i> 1. Immunization 2. Hepatitis B surface antibody <input type="checkbox"/> Reactive <input type="checkbox"/> Non-Reactive <input type="checkbox"/> Not Done	#1 ___/___ ___/___	#2 ___/___	#3 ___/___	

RECOMMENDED IMMUNIZATIONS

F. MENINGOCOCCAL: <i>One dose of one of the following is recommended for students under age 25, particularly freshmen in residence halls.</i> <input type="checkbox"/> Menomune or <input type="checkbox"/> Menactra	___/___			
G. INFLUENZA: <i>Annual immunization recommended for college students</i>	___/___			

TB SCREENING: Please complete the following Rick Assessment Questions

- Yes or No Have you had any of the following symptoms? • unexplained cough of more than 3 weeks or bloody sputum
• unexplained night sweats, weight loss or fever
- Yes or 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 or No If you have traveled or lived outside the United States to any countries **NOT** on the following list, you should be screened for TB:
- | | | | | |
|--------------------------|----------------|----------------------|-----------------------|----------------|
| 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 need to have a TB Skin Test administered in the United States.

(Previous BCG vaccination does not exempt patient from TB testing.)

TB Test (if required) Date Administered: _____ Date Read: _____ Reaction in Millimeters: _____

QuantiFERON-TB Gold Blood Test (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.

PHYSICIAN'S NAME (Please Print)

SIGNATURE

DATE

OVERVIEW OF MENINGOCOCCAL DISEASE

DISEASE INFORMATION

Meningococcal disease is an acute bacterial infection that strikes nearly 3,000 Americans each year. Adolescents and young adults are particularly vulnerable to the disease, accounting for nearly 30 percent of all cases in the U.S. A recent study found one in four adolescents infected will die, and those who survive, up to 20 percent 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 (*meningococemia*), and they are caused by the same bacteria (*Neisseria meningitidis*).

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

In May 2005, the Centers for Disease Control and Prevention issued recommendations calling for routine vaccination with meningococcal conjugate vaccine for college freshmen living in dormitories. **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 they have not previously been 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 *Neisseria Meningitidis*. 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 or clinics.

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 Pediatrics, www.aap.org
- American Academy of Family Physicians, www.aafp.org
- American College Health Association, www.acha.org
- National Foundation for Infectious Diseases, www.nfid.org

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 a 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 medical record for treatment. All the 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 Aldersgate Center, if it is deemed necessary to prevent a serious threat to your health and/or safety.

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

Your 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 medical record.
2. Provide you with notice of our legal duties and privacy practices regarding your 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 violated, 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.