HEALTH RECORDS FORM

900 East Washington Street
Greensboro, North Carolina 27401
Phone: (336) 517-2230 Fax: (336) 332-0160

Dear Bennett Belle:

We look forward to providing you with exemplary service at the Bennett College Student Health Center. The Student Health Center provides a variety of medical and other health services to our students. The regular office hours are Monday – 8:00am – 4:00pm; Tuesday – 9:00am – 3:00pm; Wednesday – 10:00am – 3:00pm; Thursday – 9:00am – 3:00pm and Friday – 9:00am – 2:00pm (hours are subject to change)

North Carolina state law (general statute 130A-155.1) requires that all students entering college must present a certificate of immunization. Prior to your enrollment at Bennett College, you are required to submit an official record of immunizations.

Additionally, the Bennett College Student Health Center requests the following medical forms which provide information that will help expedite health services, should the need arise. They include the Demographic, Emergency Contact and Insurance Form, Consent Disclosure Information, a Verification and Authorization to Treat Form and Family & Personal History Form. Each form may be found in this packet.

Please attach copies of any records verifying your immunizations. This information may be obtained from a number of sources, such as your pediatrician, parents, armed services, high school, and/or other health sources. **Please submit all forms to the Bennett College Health Center using one of the below methods on or before August 1**, at the following address:

ATTN: Records
Bennett College Student Health Center
900 East Washington Street
Greensboro, NC 27401
(336) 332-0160 (fax)
Health_center@bennett.edu (email)

If you have any questions, please contact us at 336-517-2230 or at Health_Center@bennett.edu. We look forward to working with you, and welcome to Bennett College.

Sincerely,

Bennett College Health Center

INSTRUCTIONS FOR COMPLETION OF HEALTH FORMS

Each of the following pages must be completed in its entirety and submitted to the **Student Health Center** by July 15. All pages and all sections are required, along with signatures and office stamps of medical personnel completing the immunization form.

Page 5. Demographic, Emergency Contact and Insurance Information

1. Complete name, address, phone number, ID, DOB, age, enrollment date by semester and year.
2. Complete enrollment classification.
3. Complete "Emergency Contact Person" section, indicating who should be contacted in the event of a medical emergency.
4. Complete information about health insurance. Be sure to note insurance policy and group numbers.

Page 6. Immunization Record – Please have your medical provider complete this section.
TO MEDICAL PROVIDER: *Please note all immunizations administered to patient, sign record, and place official stamp in appropriate place. North Carolina state law mandates that students have the following immunizations.*

1. Tdap Booster (tetanus/diphtheria/pertussis) – Booster, Tdap booster is not required for students over the age of 64 years.
2. Please indicate the date of at least 3 DTPs (diphtheria/tetanus/pertussis) done prior to the booster.
3. Polio series should be completed with 3 vaccinations.
4. Record of 2 MMR vaccines for measles, mumps, and rubella. This vaccine is not required of any student born prior to 1957.
5. Meningococcal conjugate vaccine for meningitis required for all freshwomen and new students (MenACWY): two (2) doses for students born after 01/01/2003. One booster dose must be after age 16.
6. The PPD skin test (to rule out tuberculosis) must be placed and read before coming to campus. If PPD is greater than 10mm induration, a chest x-ray must be obtained. If the chest x-ray is abnormal, INH treatment should be initiated or other TB prophylaxis treatment.
7. Hepatitis B vaccine – 3 doses required for any student born after July 1994
8. Varicella – 2 doses (required if born on or after April 1, 2001).

Page 7. New Patient Consent to the Use and Disclosure of Health Information
This form allows the students to indicate how she would like her medical information used and how she would like to communicate with the Student Health Center. This form should be reviewed and signed by the student, and parent/guardian of students under age 18.

Page 8. Verification & Authorization to Treat – Please read and sign at appropriate places.

Page 9. Family & Personal History – Please complete.

IMMUNIZATIONS ARE REQUIRED BY NC STATE LAW TO ATTEND COLLEGE. PLEASE MAKE YOUR APPOINTMENT TODAY TO COMPLETE YOUR IMMUNIZATIONS.

DEMOGRAPHIC, EMERGENCY CONTACT AND INSURANCE INFORMATION

Please complete in black ink or type.
Return to:

Bennett College Health Center
900 East Washington Street
Greensboro, North Carolina 27401
Phone: (336) 517-2230 Fax: (336) 332-0160

NAME _____
LAST **FIRST** **MI**

PERMANENT ADDRESS:

_____
STREET **CITY** **STATE** **ZIP CODE**

PHONE NUMBER: ( ) _____ BENNETT COLLEGE ID: _____

DATE OF BIRTH: _____ AGE: _____

DATE OF ENROLLMENT (Semester/Year): **Fall _____ Spring _____**

ON CAMPUS ____YES ____NO ON CAMPUS RESIDENCE HALL AND ROOM #_____

CLASS YOU ARE ENTERING (circle)**: FR. SO. JR. SR.**

PREVIOUSLY ENROLLED AT BENNETT COLLEGE: ☐ YES ☐ NO

EMERGENCY CONTACT:

NAME _____ RELATIONSHIP _____

ADDRESS _____

CITY, STATE, ZIP _____

DAYTIME PHONE NUMBER ( ) _____

NIGHTTIME PHONE NUMBER ( ) _____

HOSPITAL/HEALTH INSURANCE (NAME AND ADDRESS OF COMPANY) TELEPHONE

NAME OF POLICY HOLDER EMPLOYER

POLICY OR CERTIFICATE NUMBER GROUP NUMBER

IMMUNIZATION RECORD **(please print in black ink)**

To be completed by a physician or clinic. A complete immunization record from a physician or clinic may be attached to this form.

Last Name First Name Middle Name	Date of Birth (mm/dd/yr)	Bennett ID Number

IMMUNIZATIONS (**REQUIRED**)				
	Month/day/yr	Month/day/yr	Month/day/yr	Month/day/yr
DTP or Td	(#1)	(#2)	(#3)	(#4)
Tdap Booster (within past 10 yrs.) *not required for students 65 years old or older.				
Polio				
MMR Series (after first birthday)				
Measles – 2 doses (after first birthday)				
Mumps – 2 doses				
Rubella – 1 dose				
Hepatitis B Series (required for any Student born after July 1994)	(#1)	(#2)	(#3)	
Meningococcal (Meningitis Vaccine)-MenACWY (2 doses)				
Varicella (chicken pox) – 2 doses				
Tuberculin (PPD) Test (done within 12 months prior to admission) *Tine Test not acceptable*				
Chest x-ray if positive PPD Date Results:				
Treatment, if applicable Date:				
IMMUNIZATIONS (RECOMMENDED)				
Haemophilus influenzae Type B				
Pneumococcal				
Hepatitis A Series				
Flu (influenzae)				
COVID				

Signature or Clinic Stamp **REQUIRED**

Signature of Physician/Physician Assistant/Nurse Practitioner Date

Print Name of Physician/Physician Assistant/Nurse Practitioner Date

Office Address and Telephone Number

NEW PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I, _____, understand that, as part of my healthcare, the **Bennett College Student Health Center** originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health care professionals who contribute to my care.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I have been provided with and understand a **NOTICE OF INFORMATION PRACTICES** that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that **Bennett College Student Health Center** is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Federal Regulations.

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

_____

_____

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.
I fully understand and accept the terms of this consent.

I wish to be contacted by the Student Health Center as they need to communicate important medical information to me in the following manner: (Check all that apply)

☐ Home telephone _____
☐ O.K. to leave a message with detailed information
☐ Leave message with call-back number only
☐ Written communication
☐ O.K. to mail to my home address
☐ O.K. to fax to this number: _____

_____ _____
Parent / Student Signature Date

VERIFICATION AND AUTHORIZATION TO TREAT

I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless by Court order. However, if I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission for the Student Health Center to release information for my/my daughter's medical record to a physician, hospital, or other medical agency involved in providing me/her with emergency treatment and/or medical care.

_____ _____
Print Name Date

_____ _____
Signature of Student Date

_____ _____
Signature of Parent/Guardian Date
(students under the age of 18)

AUTHORIZATION TO TREAT:

I hereby authorize the medical providers of the **Bennett College Student Health Center** and their agents or consultants, including those at area hospitals, to perform diagnostic and treatment procedures, on the above-named student, which in their judgment may become necessary while she attends **Bennett College**. As the parent, I waive all claims to prior notification. I understand that officials of Bennett College will make every effort to notify me once permission is obtained from the student in the event of a major illness or injury.

_____ _____
Print Name Date

_____ _____
Signature of Student Date

_____ _____
Signature of Parent/Guardian Date
(students under the age of 18)

FAMILY & PERSONAL HISTORY (please print in black ink) **To be completed by student**

STUDENT'S NAME:_____ ID NUMBER:_____ DATE:_____

The following health history is confidential, does not affect our admission status and, except in an emergency situation or by court order, will not be released without your written permission. Please attach additional sheets for any items that require further explanation.

Has any person, related by blood, had any of the following?

	Yes	No	Relationship		Yes	No	Relationship		Yes	No	Relationship
High blood pressure				Cholesterol or blood fat disorder				Cancer (type)			
Stroke				Diabetes				Alcohol/drug problems			
Heart attack before age 55				Glaucoma				Psychiatric illness			
Blood or clotting disorder				Asthma				Suicide			

Have you ever had or have now: (please check at right of each item, and, if yes, indicate year of first occurrence)

	Yes	No	Yr.		Yes	No	Yr.		Yes	No	Yr.		Yes	No	Yr.
High Blood Pressure				Hay fever				Jaundice or hepatitis				Protein or blood in urine			
Rheumatic fever				Allergy injection therapy				Rectal disease				Hearing loss			
Heart trouble				Arthritis				Severe or recurrent abdominal pain				Sinusitis			
Pain or pressure in chest				Concussion				Hernia				Severe menstrual cramps			
Shortness of breath				Frequent or severe headache				Easy fatigability				Irregular periods			
Asthma				Dizziness or fainting spells				Anemia or Sickle Cell Anemia				Sexually transmitted disease			
Pneumonia				Severe head injury				Eye trouble besides needing lasses				Blood transfusion			
Chronic cough				Paralysis				Bone, joint or other deformity				Smoke (# cigarettes a day ___)			
Tuberculosis				Epilepsy /seizures				Shoulder dislocation				Alcohol use			
Head or neck radiation				Disabling depression				Knee problems				Drug use			
Tumor or cancer (specify)				Excessive worry or anxiety				Recurrent back pain				Anorexia/Bulimia			
Malaria				Ulcer (duodenal or stomach)				Neck injury				Other (specify)			
Thyroid trouble				Intestinal trouble				Broken bone (specify)				Serious skin disease			
Diabetes				Pilonidal cyst				Mononucleosis				Gall bladder trouble or gallstones			
Insulin dependence				Kidney infection				Kidney stones				Personal trauma			
Constance/frequent vomiting				Kidney failure				Bladder infection							

Please describe any conditions or disabilities that would exclude participation in physical education_____
Do you exercise three or more times per week? Yes____ No____
Do you need assistance with academic support? Yes____ No____ If yes, please explain_____

Please list any drugs, medicines, birth control pills, vitamins, and minerals (prescription or nonprescription) you use and indicate how often you use them.

***Name**_____**Use**_____**Dosage**_____ ***Name**_____**Use**_____**Dosage**_____

***Name**_____**Use**_____**Dosage**_____ ***Name**_____**Use**_____**Dosage**_____

Have you ever experienced adverse reactions (hypersensitivities, allergies, upset stomach, rash, hives, etc.) to any of the following? If yes, please explain fully the type of reaction, your age when the reaction occurred, and if the experience has occurred more than once.

	Yes	No	Explanation
Penicillin			
Sulfa			
Other antibiotics (names)			
Aspirin			
Codeine or other pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Food allergies (name)			
Have you ever been a patient in any type of hospital? (Specify when, where, and why)			
Have you ever been treated, hospitalized, or presently on medication for emotional problems?			
Is there loss or seriously impaired function of any paired organ? (Please describe)			
Have you ever had a serious illness or injuries other than those already noted? (specify when, where, and give details)			