

Susquehanna University
Health Center
514 University Avenue, Selinsgrove, PA 17870-1001
Health Center Phone (570) 374-9164 - Fax (570) 372-2729

Items to know when completing your health record:

- Please keep your health record in its original order - DO NOT remove staples from health record and please DO NOT staple additional papers to health record. Any additional papers should be placed, unattached, in the envelope along with your completed health record.
- Return your health record when it is FULLY completed. Incomplete health records will be returned.
- A physical is required six months prior to arriving on campus. This is for your protection as well as the protection of our campus community.
- It is important that your immunizations be up-to-date. To obtain dates for your immunizations, contact your pediatrician or high school. For those immunizations not covered by your health insurance, some may be obtained for free or at a discounted rate through your local Department of Health.
- The student's signature is required on pages 3 and 7. A physician's signature is required on page 4.

Frequently asked questions:

Q - What if I do not hand in a health record or hand in an incomplete health record?

A - *Missing or incomplete health records will place a hold on you receiving your room key the day you arrive on campus (please see the back of this page for our "Key Hold" policy).*

Q - My insurance only covers a physical once a year. Am I still required to have a physical six months before I arrive on campus?

A - *Yes, physicals prior to six months will not be accepted and will cause your health record to be incomplete. Sports physicals within this time frame are also accepted (please include copy of physical when returning your health record).*

Q - Does my private insurance cover me when I am away from home?

A - *All health insurances vary. It is very important to know your coverage before leaving home. Before arriving on campus, phone your insurance company to inform them that you will be attending college away from home and ask them if you need to change your primary care provider to a care provider located near the University. Although you do have coverage through your school insurance, this insurance will only cover at 50% if your home insurance refuses payment due to you being seen out of network. Please include a copy of your insurance card with your health record and have a copy of your insurance card with you when you arrive on campus.*

Q - Do I need to pay the Health Center insurance fee if I have my own private insurance?

A - *Yes, it is mandatory for all students to pay the insurance and health fee. The Business Office will send you information regarding student health insurance. You will be billed for the health insurance as part of your student health fee. This insurance is an in-excess plan and, in most cases, is secondary to your private insurance. Visits to the Health Center and referrals from the Health Center for lab work and x-rays are covered under the school policy provided they are within the plan limits. In cases where charges exceed the plan limit, claims will be submitted to the student's private insurance first. It is important to remember that your school insurance has minimal coverage and private insurance should not be cancelled due to this extra coverage. In most instances the maximum the school insurance will pay per sickness is \$500. To find more - information about the school's insurance policy, please visit our web page at www.susqu.edu/health (the 09-10 policy is currently listed but as soon as the 10-11 policy becomes available, the website will be updated---there are usually only minor changes in the policy from year to year).*

Q - Can the Health Center share information with my parents without my consent?

A - *No, students are, by law, considered adults (no matter who pays a student's tuition fee) and information obtained in the Health Center can only be shared with parents if a student signs a release to share this information. The Consent to Release health information can be signed by students in the Health Center any time after August 30th.*

Q - What do I do if I am not feeling well and need to be seen by a care provider?

A - *The Health Center has physician appointments daily (please check the Health Center's web page @ www.susqu.edu/health for physician hours). The physician is seen by appointment only and appointments fill very quickly so please either stop at the Health Center first thing in the morning to see a nurse or phone the Health Center first thing in the morning to speak to a nurse, who will schedule you for an appointment.*

Q - Can I obtain my allergy shots in the Health Center?

A - *Yes, however, this service is only offered during physician hours. The initial allergy injection must be received at the student's immunologist's office. Titrating or maintenance doses can be administered at the Health Center. The Health Center can store your allergy record and vials, however, allergy vials cannot be mailed to the Health Center. Please bring them to the Health Center yourself. We ask that students remain at the Health Center for 30 minutes after allergy injections.*

Q - My family physician prescribes medication to treat my ADD/ADHD. Do you provide this service at the Health Center?

A - *No, we encourage you to continue your treatment for ADD/ADHD as you had previously. Please schedule appointments during your semester breaks for maintenance of prescriptions as needed. The Health Center is not involved in any screening or treatment processes.*

Student - Please keep this page for your records.

**Susquehanna University
Health Center**

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Susquehanna University's Health Center is dedicated to the protection of confidential patient health information. The Health Center staff makes your privacy a high priority. Each time you visit the Health Center, we make a record of the care and services provided. This record is necessary so we can provide quality health care to you as well as meet our obligations to certain state and federal laws. This notice will explain some, but not all, ways we may use and/or share health information. We are required by law to keep your health information private. This protection includes oral, written, and electronic private health information. We are required by law to give you this Notice and to follow its present terms.

We reserve the right to change our privacy practices and the terms of this Notice provided these changes are permitted by law. We have the right to make these changes effective for all health information we have about you, including information created or received prior to the change. Before we make significant changes to our privacy practices, we will change this notice and make a copy available upon request. This Notice is in effect April 14, 2003 and will remain in effect until changed.

USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION

In the following instances, health information may be disclosed without your express authorization:

Treatment - The Health Center may use/disclose your health information to provide treatment, coordinate services, and manage your continued health care.

Payment - The Health Center may use/disclose health information for the purpose of receiving payment or obtaining reimbursement to you. This may also include contacting your insurer to verify benefits or to obtain the needed authorization for treatment.

Health care operations - The Health Center may use/disclose health information and perform health care operations such as, but not limited to, quality assessment and improvement activities, employee performance appraisals, risk management, employee training, obtaining accreditation/licensure/certificates.

Appointment reminder - The Health Center may use/disclose health information to the extent of reminding you of an appointment or provide you with information on alternative treatments or other services which may be of interest to you.

Notification and disaster relief - The Health Center may release health information in contacting a friend or family member who is involved in your care concerning your location and general condition unless you specifically ask the staff not to share this information. The Health Center may also release health information to disaster relief organizations.

As required by law - Including, but not limited to, the Health Center will release your health information as required by state and/or federal law as applicable for the purposes of public health, abuse/neglect/domestic violence, legal proceedings, national security, and law enforcement.

Military activity - The Health Center may use/disclose health information if you are in the armed forces and is required by command authorities or for reasons of benefit determination by the Department of Veteran Affairs.

Worker compensation - When necessary to comply with laws relating to workmen's compensation or similar programs, the Health Center may release health information.

- **Medical examiners, coroners, funeral directors** - Medical information may be used/disclosed by the Health Center to funeral directors, medical examiners, coroners, or organ procurement organizations to aid them in carrying out their duties.
- **Disclosure without authorization** - When information is required to be disclosed without your authorization, the Health Center will provide the least amount of information necessary to satisfy the purpose of the disclosure.

OTHER USES AND DISCLOSURES

The Health Center will release patient information for purposes other than those above with a written authorization signed by you. Verbal permission will be accepted only under certain circumstances when written authorization cannot be practically obtained and will be well documented in your chart. You may withdraw your authorization in writing at any time. Your withdrawal will be effective upon our receipt of your written request.

Policy Statement: Key Holds When Medical Records Are Incomplete

Completed Health Center records are due in July. Accurate and current Health Records enable the Health Center to provide appropriate medical care to students. Immunizations are required in order to protect the health of the community. Therefore, students who have not returned completed health records, including immunizations, will be denied their room key when they check-in during orientation. Ample time and reminders has been allowed for the completion of these records.

Students who may need last-minute immunizations must contact the Health Center to make appropriate arrangements. Limited immunizations are available through the Health Center for a fee, however a local physician appointment may be necessary to complete these forms at the student's expense. Students should contact the Health Center regarding any questions or concerns.

Procedures:

1. The Health Center will generate a list of students who have incomplete or missing health records.
2. The list will be delivered to Residence Life before orientation.
3. Students who are on the list will be referred by Residence Life to the Health Center before they can receive their key.
4. The Health Center will provide a clearance form for the student to return to Residence Life in order to secure their key.
5. Health Records that remain incomplete place the student in a "Health Hold" situation, barring registration from classes until this matter is completed.

IMPORTANT: PLEASE DO NOT REMOVE STAPLE - KEEP RECORD IN ITS ORIGINAL ORDER - DO NOT RETURN RECORD UNTIL FULLY COMPLETE

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Counseling Center Phone (570) 372-4751

Information you provide will not be used to influence your situation at the University; it will be used solely as an aid to provide health care while you are a student. This information is strictly for the use of the Health Center, and sharing of information is governed by the enclosed HIPAA regulations.

**Must be returned to the Health Center before July 16th
or a hold will be placed on your registration and/or your room key will be held.**

SECTIONS 1, II, III, IV, and V TO BE COMPLETED BY STUDENT (PLEASE PRINT NEATLY IN BLACK INK)

Part I - PERSONAL DATA

Name: _____
Last First Middle

Date of Birth: _____ Social Security No: _____
Month Day Year - -

Semester you are entering (circle): Fall Spring Class you are entering (circle): FR SO JR SR

Previously Enrolled at Susquehanna University (circle): No Yes If Yes, year(s) enrolled: _____

Female___ Male___ Transgender___ Marital Status: _____ Citizenship: _____ Religion: _____

Home Address: _____
No. & Street City/Town State Zip

Country of Origin if other than United States: _____

Home Phone: _____ Student's Cellular Phone: _____

In case of an emergency notify: _____
Name Relationship Home Phone

_____ Home Address Cellular Phone Business Phone
Family Physician: _____ Phone: _____

Address: _____

***** Official Health Center Use (please do not write in this section) *****

Student Label

Student's Name:

Part II - FAMILY AND PERSONAL HISTORY

FAMILY HISTORY

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

	Yes	No	Relationship
High Blood Pressure			
Stroke			
Heart Attack Before Age 55			
Blood or Clotting Disorder			
Cholesterol or Blood Fat Disorder			
Diabetes			
Glaucoma			

	Yes	No	Relationship
Cancer - Specify Type:			
Psychiatric Illness			
Dementia			
Anxiety			
BiPolar			
Suicide			
Other-Specify:			

PERSONAL HISTORY

Do you have any known allergies? If so, please list:

	Yes	No	Specify Allergy
Drug			
Food			
Other			

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

	Yes	No	Year
Blood Pressure Fainting - Specify:			
Rheumatic Fever			
Heart Problems - Specify:			
Breathing Difficulties - Specify:			
Tuberculosis			
Cancer - Specify:			
Thyroid Problems - Specify:			
Diabetes			
Intestinal Problems - Specify:			
Kidney Problems - Specify:			
Allergy Injection Therapy			
Concussion:			
Epilepsy / Seizures			
Chicken Pox			
Jaundice or Hepatitis			
Anemia / Blood Problems - Specify:			
Eye Problems - Specify:			
Orthopedic Problems - Specify:			
Mononucleosis			
Hearing Loss			
Menstrual Problems - Specify:			
Blood Transfusion			
Smoke - Number of Cigarettes a Day:			
Serious Skin Disease			
Other - Specify:			

Student's Name: _____

Part III - MENTAL HEALTH/SOCIAL HISTORY

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

	Yes	No	Year
Depression			
Anxiety			
Bipolar disorder			
Eating disorder			
Alcohol/drug abuse or dependence			
Other mental health concerns - Specify:			

Please indicate if you have had the following experiences:

	Yes	No	Year
Attended counseling for mental health concerns			
Taken a prescribed medication for mental health concerns			
Been hospitalized for eating disorder 1 mental health concerns			
Received treatment for alcohol or drug abuse			

Please note that this information, like all of your health information, is confidential. The Health Center and the Counseling Center are separate departments. With your permission, the Health Center can share your mental health/social history with the Counseling Center. If you choose to have this information shared with the Counseling Center, they will send you information about services after you have begun classes.

(Please check one)

I do do not give permission to share the above mental health/social history information with the Counseling Center.

Student's signature: _____ Date: _____

Part IV and V - To be completed by a health care provider

Must be returned to the Health Center before July 16th or a hold will be placed on your registration and/or your room key will be held.

Part IV - REPORT OF PHYSICAL EXAMINATION

Physical MUST be completed no sooner than six months prior to the first day of classes which begin August 30, 2010.

Patient Name: _____ Female ____ Male ____

Temperature: _____ Pulse: _____ Respiration: _____
Last First Middle

Height: _____ Weight: _____ BP: _____

Date of Physical: _____ (Must be completed no sooner than six months prior to the first day of classes on August 30, 2010.)

Are there abnormalities of the following systems? Please describe fully.

System	NORMAL	ABNORMAL	Comments
1. Head, Ears, Nose, or Throat			
2. Eyes			
3. Respiratory			
4. Cardiovascular			
5. Gastrointestinal			
6. Hernia			
7. Genitourinary			
8. Musculoskeletal			
9. Neuropsychiatric			
10. Skin			

Is there loss or seriously impaired function of any organ? No ___ Yes ___ Explain: _____

Recommendations for physical activity: Unlimited: _____ Limited: _____ Explain: _____

Has the patient ever been treated for an eating disorder? No ___ Yes ___ Explain: _____

Has the student ever been treated for any other mental health condition? No ___ Yes ___ Explain: _____

Is the student currently under treatment or had treatment within the past year for any medical or mental health condition? No ___ Yes ___
Explain: _____

Do you have any recommendations regarding the care of this student? No ___ Yes ___ Explain: _____

How long have you known this student? _____ Do you have any general comments? _____

If you have any additional recommendations, please feel free to include a note or letter with this health record.

MUST BE SIGNED BY HEALTH CARE PROVIDER:

Health Care Provider's Signature: _____ Date: _____

Health Care Provider's Name Printed: _____

Address: _____

Phone: () _____ Fax: () _____

Part V - IMMUNIZATION RECORD

To be completed and signed by a health care provider
(Dates must include month, day (if available), and year. All information must be in English)

The following immunizations are for your protection as well as that of the University community.
*Must be returned to the Health Center before July 16th or a hold will be placed on your registration and/or your room key will be held.
If you have problems obtaining your immunizations, contact your local Department of Health or high school for possible assistance.*

Section I

Name: _____
Last First Middle

Home Address: _____
No. & Street City/Town State Zip

Date of Entry to SU: _____ Date of Birth: _____ Social Security No.: _____

Section II

The following are required immunizations and screenings

A. MMR (Measles, Mumps, Rubella) - Two doses required.

- 1. Dose 1 given at age 12-15 months or later#1 / /
M D Y
- 2. Dose 2 given at age 4-6 years or later, and at least one month after first dose#2 / /
M D Y

B. Tuberculosis (TB) Risk Assessment

Persons with any of the following are candidates for either Mantoux tuberculin skin testing (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented:

Risk factor:

- a) Recent close contact with someone with infectious TB disease __yes __no
- b) Foreign-born from (or travel to/in) a high prevalence area (e.g. Africa, Asia, Eastern European, or Central or South America) __yes __no
- c) Fibrotic changes on a prior chest x-ray suggesting inactive or past TB disease __yes __no
- d) Resident, employee, or volunteer in a high-risk congregate setting __yes __no

(e.g.: correctional facilities, nursing homes, homeless shelters, hospitals and other health care facilities.)

1) Does the student have signs or symptoms of active tuberculosis disease? yes no

If no proceed to 2 or 3. If Yes, proceed with additional evaluation to exclude tuberculosis disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.

2) Tuberculin Skin Test (TST) should be recorded as actual millimeters (mm) of induration diameter; if no risk indurations write "0". The TST interpretation should be based on mm of induration as well as risk factors.

Date given / / Date Read / /
Result: _____mm of induration **Interpretation: positive____negative____

3) Interferon Gamma Release Assay (IGRA)

Date obtained: / / (specify method) QFT-G QFT-GIT other____
Result: Negative ____ Positive ____ Intermediate____

4) Chest x-ray: (Required if TST or IGRA is positive)

Date of Chest x-ray: / / Result: normal ____ abnormal____

Student's Name: _____

**** Interpretation guidelines**

>5 mm positive

- Recent close contacts of an individual with infectious TB
- Persons with fibrotic changes on a prior chest x-ray consistent with past TB disease
- Organ transplant recipients
- Immunosuppressed persons: taking > 15mg/d of prednisone >1 month; taking a TNF-@ antagonist
- Persons with HIV/AIDS

>10 mm is positive:

- Persons born in a high prevalence country or who resided in one for a significant* amount of time
- History of illicit drug use
- Mycobacteriology laboratory personnel
- History of resident, worker or volunteer in high-risk congregate settings
- Persons with the following conditions: scoliosis, diabetes mellitus, chronic renal failure, leukemias and lymphomas, head, neck or lung cancer, low body weight (> 10% below ideal) gastrectomy or intestinal bypass, chronic malabsorption syndrome

>15mm is positive

- Persons with no known risk factors for TB disease

**The significance of the exposure should be discussed with a Health Care provider and evaluated*

C. Tetanus-Diphtheria –Pertussis- Primary series with DtaP or DTP and booster with Tdap in the past ten years meets requirements. (Refer to ACIP* for details)

1. Primary series for doses with DtaP or DTP: #1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___
M D Y M D Y M D Y M D Y

2. Tetanus-Pertussis-Diphtheria (Tdap) booster within the last ten years ___/___/___
M D Y

**ACIP Recommendations*

Tdap (Tetanus, diphtheria, acellular pertussis)

Give 1-time dose of Tdap to all adolescents who have not received previous Tdap. If previously received Td booster, an interval of 2 years or less between Td and Tdap maybe used.

D. Polio - Primary series in childhood meets requirement; three primary series schedules are acceptable. (Refer to ACIP for details)

1. OPV alone (oral Sabin three doses): #1 ___/___/___ #2 ___/___/___ #3 ___/___/___
M D Y M D Y M D Y

E. Hepatitis B (Three doses of vaccine or a positive Hepatitis surface antibody meets the requirement.)

1. Immunization a. Dose #1 ___/___/___ b. Dose #2 ___/___/___ c. Dose #3 ___/___/___
M D Y M D Y M D Y

Hepatitis B surface antibody: Date: ___/___/___ Result: Reactive Non-reactive
M D Y

F. Meningococcal Immunization

(A, C, Y, W-135) (Quadrivalent MCV4 Preferred)

- Polysaccharide (Acceptable alternative if conjugate not available)

One or 2 doses for all college students:

Booster dose required if initial dose given age <16 yrs of age

If initial dose given age ≥16 yrs, no booster dose required

1. Quadrivalent conjugate a. Dose #1 ___/___/___ b. Dose #2 ___/___/___
M D Y M D Y

2. Quadrivalent polysaccharide (acceptable alternative if conjugate not available). Date ___/___/___
M D Y

Student's Name: _____

Part VI - NOTICE OF PRIVACY PRACTICES

This section pertains to the enclosed Notice of Privacy Practices which pertains to the Health Center's uses and disclosures of your medical information.

IMPORTANT NOTE: The Susquehanna University Health Center is located near the Geisinger Pediatric Emergent Care Facility. With the student's consent, records will be shared with this facility, as needed, for referrals.

ACKNOWLEDGEMENT OF INFORMATION PRACTICES

As part of my health care, the Health Center creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results, and plans for future care.

- I understand that this information serves as a basis for my continuing care.
- I understand that this information is used as a means of communication among the Health Center personnel and with medical personnel outside of this practice.
- I understand that this information serves as a source of information for applying my diagnoses and surgical information for billing purposes.
- I understand that this information is a way for third party insurance companies to assure that a service that was billed for was actually performed.
- I understand that this information can be used as a tool to assess the quality of care provided to patients.
- I have been provided an opportunity to review the *Notice of Privacy Practices* for the Health Center that provides a more complete review of information uses and disclosures.
- I understand that I have the right to review this *Notice of Privacy Practices* before signing this consent.
- I understand that the Health Center may change their information practices at any time and that a current copy will be available for my inspection during regular business hours.

Student's Signature: _____ **Date:** _____

Student's Name: _____

Part VII - HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION:

Name of Primary Health Insurance Company: _____
Insurance Company Phone Number _____

Policy Number	Identification Number	Group Number	Plan		
Policy Subscriber's Information:					
Subscriber's Name (as it appears on card)	Last Name	First Name	MI	Date of Birth	Gender
Effective date	Employer	Employer's Phone Number			
PPO	Y	N	Subscriber Relationship to Patient		

SECONDARY INSURANCE INFORMATION (If Applicable):

Name of Secondary Health Insurance Company: _____
Insurance Company Phone Number _____

Policy Number	Identification Number	Group Number	Plan		
Policy Subscriber's Information:					
Subscriber's Name (as it appears on card)	Last Name	First Name	MI	Date of Birth	Gender
Effective date	Employer	Employer's Phone Number			
PPO	Y	N	Subscriber Relationship to Patient		

PRESCRIPTION COVERAGE INFORMATION: Do you have a prescription plan? No Yes. If yes, what is your co-pay?

Name of prescription plan/company: _____ Group No.: _____

IMPORTANT NOTE:

With your health record, please include a copy of your insurance card and prescription card and make sure you have a copy to carry with you.

Before arriving on campus, **phone your insurance company to inform them that you will be attending college away from home** and ask them if you need to change your primary care provider to a care provider local to the University. The Susquehanna University Health Center is located near the Geisinger *Medical Center Pediatric Emergent Care Facility*. Referrals may be made to this facility, as needed. Other local hospital can be found on the Health Center web page. It is **important to know your coverage before leaving home**. It is mandatory for all students to purchase insurance thru the University (included in your tuition fee). This insurance is an in-excess plan and, in most cases, is secondary to your private insurance. Visits to the Health Center and referrals from the Health Center for lab work and x-rays are covered under the school policy provided they are within the plan limits. In cases where charges exceed the plan limit, claims will be submitted to the student's private insurance first. To find more information about the schools insurance policy, please visit our web page at www.susqu.edu/health