Bennett College Student Health Center
900 East Washington Street
Greensboro, NC 27401

HEALTH RECORDS FORM

Dear Bennett Belle:

We look forward to providing you 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-Friday from 8:00 a.m. to 12:00 p.m

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 and a Verification and Authorization to Treat 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 department sources. Please submit all forms to the Bennett College Health Center on or before August 1, at the following address:

ATTN: Records
Bennett College Student Health Center
900 East Washington Street, Box 5
Greensboro, NC 27401

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,

Veita Bland, MD
College Physician

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 August 1. All pages and all sections are required, along with signatures and office stamps of medical personnel completing the immunization form.

Demographic, Emergency Contact and Insurance Information

1. Complete name, address, phone number, SSN, 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.

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.*

Tdap Booster (tetanus/diphtheria/pertussis) – Booster, Tdap booster is not required for students over the age of 64 years. Please indicate date of at least 3 DTPs (diphtheria/tetanus/pertussis) done prior to the booster.

1. Polio series should be completed with 3 vaccinations.
2. Record of 2 MMR vaccines for measles, mumps and rubella. This vaccine is not required of any student born prior to 1957.
3. Menomune vaccine for meningitis required for all freshwomen and new students.
4. The PPD skin test (to rule out tuberculosis) must be placed and read before coming to campus. If PPD is greater than 10mm indurations, a chest x-ray must be obtained. If the chest x-ray is abnormal, INH treatment should be initiated or other TB prophylaxis treatment.
5. Hepatitis B vaccine – 3 doses required for any student born after July 1994.

Page 4. 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 5. Verification & Authorization to Treat – Please read and sign at appropriate places.

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:
900 East Washington Street, Box 5
Greensboro, North Carolina 27401
Phone: (336) 517-2230 Fax: (336) 517-2235

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 _____**

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 POLICY HOLDER'S SSN EMPLOYER

POLICY OR CERTIFICATE NUMBER GROUP NUMBER

Print Name of Physician/Physician Assistant/Nurse Practitioner **Date**

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

To be completed by 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/year	Month/day/year	Month/day/year	Month/day/year
DTP or Td	(#1)	(#2)	(#3)	(#4)
Tdap Booster (within past 10 yrs.) *not required for students 65 years old or older.				
Polio				
MMR (after first birthday)				
MR (after first birthday)				
Mumps				
Rubella				
Hepatitis B Series (required for any Student born after July 1994)	(#1)	(#2)	(#3)	
IMMUNIZATIONS (RECOMMENDED)				
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:				
Haemophilus influenzae Type B				
Pneumoccoccal				
Meningococcal (Meningitis Vaccine)				
Hepatitis A Series				
Typhoid (specify type)				
Varicella (chicken pox)				

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 every effort will be made by officials of **Bennett College** 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)