COVENANT
COLLEGE

REPORT OF MEDICAL HISTORY

COVENANT COLLEGE

Priesthill Center

Health Services

TO THE STUDENT: Please complete this entire form. Information provided will be used as an aid in providing necessary care while you are a student. The form will not affect admission decisions but must be filled out completely and mailed to the Admissions Office, Covenant College, Lookout Mountain, GA 30750. This information is strictly for the use of the Health Services Office and will not be released to anyone without your knowledge and written consent.

CURRENTLY ENROLLING: ___ SPRING ____FALL, 20____

ENTERING CLASS: Freshman Sophomore Junior Senior (circle class level) **Previously Enrolled: Y N** (circle)

Last Name First Name Middle Social Security Number

Home Address City State Zip Telephone Number

Student's Cell Phone Student's e-mail address Parents' e-mail address

Date of Birth: Sex: M F (circle) Marital Status: S M Other (circle)

Name of Emergency contact information / Parent or Guardian

Phone (home) Phone (cell) (office)

Relationship to student

IN ALL THINGS CHRIST PREEMINENT

Name: _____

Print *Last* *First* *Middle* *Banner ID #*

PERSONAL MEDICAL HISTORY

Comment on the back of this form on all positive answers or have your physician send a summary to the Health Services Office. It is very important that you answer **ALL** questions below.

Have you had:	Yes	No		Yes	No		Yes	No		Yes	No
Eye Trouble: Describe _____			Rheumatic Fever			Bone / Joint Problems			Kidney Disease		
Contacts			High Blood Pressure			Stomach / intestinal problems			Thyroid Problems		
Glasses			Heart Murmur			Epilepsy or Convulsions			Anemia		
Ear, Nose or Throat problems			Heart Problems _____			Diabetes			ADD or ADHD Medication: _____		
Allergies			Abnormal Pap Smear			HIV Positive			Positive TB Skin Test		
Asthma			Infectious Mononucleosis			Hepatitis or Jaundice			Gynocological Problems		
Frequent or severe headaches			Depression			Skin Problems			Other_____		

Do you have any disease which should be periodically evaluated? Yes No If Yes, which disease _____

Please list all prescription medication you take. List name, dose, and how it is taken:_____

_____

Are you allergic to any medication? Yes No If yes, please list _____

What allergic reaction did you have to this medication? _____

Do you have any chronic illness? Yes No If yes, please list _____

Have you ever been hospitalized? Yes No Reason _____

Have you ever been injured? Yes No If yes, explain _____

Have you ever interrupted school or work due to mental or emotional illness? Yes No If yes, explain_____

STUDENTS 18 OR OLDER

I hereby authorize the medical staff of Covenant College Health Services, their agents or consultants, to the treatment necessary for my care. I authorize the release of my medical records to my insurance company if applicable. I understand that I am responsible for any charges incurred.

X_____

Signature of Student Date

_____HOME: (____)_____ OFFICE: (___)_____CELL: (___)_____

Name of Legal Guardian and Relationship **Telephone Numbers**

PARENTS OF STUDENTS UNDER 18

I hereby authorize any medical treatment for my son/daughter that may be advised or recommended by the medical staff of Covenant College Health Services. I authorize the release of medical records to my insurance company if applicable. I understand I am responsible for any charges incurred.

X_____

Signature of Parent or Legal Guardian **Date**

Name: _____

PRINT *Last* *First* *Middle* *Banner ID #*

TB SCREENING AND IMMUNIZATION RECORD

To Be Completed By Physician OR Health Department. Please include a TB SCREENING consisting of date given/placed & result with date.

Immunizations — Date

Tetanus-Diptheria (TD, DTaP, DTP, or Tdap) BOOSTER **REQUIRED** _____

(Must be within 10 years)

Measles/Mumps/Rubella (given @ 12months or later) **REQUIRED** _____

Measles/Mumps/Rubella BOOSTER (given at least 28 days after 1st dose) **REQUIRED** ** _____

Meningitis Vaccine (receive vaccine or sign waiver pg 4) **REQUIRED** _____

Chicken Pox disease Yes No Date _____ Vaccine (**Recommended**) **#1**_____ #2_____

Hepatitis B: (**Recommended**) #1 _____ #2 _____#3 _____

Hepatitis A (**Recommended**) #1_____ #2_____

POLIO (last booster date) _____

** MMR booster not required if birth-date is before 1956

TB SCREENING REQUIRED – Not part of standard immunization record. Must be complete prior to registering for classes.

TB Skin Test: PPD (WITHIN PAST YEAR) *** **REQUIRED** ***

Date Given : _____ **PPD RESULT:** _____**mm** **Date Read:** _____

X_____

SIGNATURE OF PHYSICIAN / HEALTH DEPARTMENT OFFICIAL DATE

_____

STREET ADDRESS STATE ZIP

_____

OFFICE PHONE NUMBER

Name _____
PRINT *Last* *First* *Middle* *Banner ID #*

COVENANT COLLEGE

Priesthill Center

Health Services

Important Notice

On

Meningitis

On January 1, 2004, Georgia law requires all college students ***living in campus housing*** be informed about the meningococcal disease and the Meningitis vaccine. Please **read the following information**, **sign the appropriate statements** below and **return this form to Health Services.**

If you decide to receive the Meningitis vaccine, you can receive this vaccine at your local Health Department, from your personal physician, or physician of your choice.

Covenant College Health Services can administer the vaccine. You **MUST** call and reserve your vaccine. The cost is $110.

Please indicate the date you received your vaccine OR check the section that indicates you have been informed about Meningitis and have elected not to be immunized.

- **Meningococcal disease is a serious disease** that can lead to death within only a few hours of onset; one in ten cases is fatal; and one in seven survivors of the disease is left with a severe disability, such as the loss of a limb, mental retardation, paralysis, deafness, or seizures.
- **Meningococcal disease is contagious** but a largely preventable **infection of the spinal cord fluid** and the fluid that surrounds the brain.
- Meningitis is contracted through the saliva of an infected person or the droplets from an infected person's sneeze or cough, but not by just breathing the same air.
- Scientific evidence suggests that **college students living in dormitory facilities are at a moderately increased risk** of contracting meningococcal disease.
- **Immunization** against meningococcal disease **will decrease the risk** of the disease.

The meningococcal meningitis vaccine is 85 to 100 percent effective against four of the five most common strains of the bacteria that cause meningococcal meningitis. Studies show that up to 80 percent of cases on college campuses are vaccine preventable.

Meningitis Vaccine Reporting Form and Waiver:

_____ _____ _____
Print last name first Date

I **have read** the information above and on the following website concerning meningitis and
http://nmaus.org/about_meningitis/index.htm#symptoms

___ have received the meningitis vaccine on _____
___ have elected not be immunized.

_____
Student's Signature

If under the age of 18, a parent's signature is necessary, also.

_____
Parent's signature

Name _____

PRINT *Last* *First* *Middle* *Banner ID #*

STUDENT'S MEDICAL INSURANCE INFORMATION

Student Name: _____

☐ I **DO NOT** have medical insurance.

☐ My medical insurance information is listed below:

Policyholder's Names: _____

Policyholder's Date of Birth: _____

Policyholder's Social Security Number: _____

Relationship to Student: _____

Insurance Company Name:_____

ID Number _____ Group # _____

Company Address: _____

_____

Phone number: _____

Effective Date of Insurance: _____

Amount of Co-pay: Office visit _____ E.R. _____

Amount of Deductible:_____

Will your insurance pay for you to see our consulting physician:

Dr. Bill M. Smith (main office)
1200 Pineville Road
Chattanooga, TN

(satellite office)
100 McFarland Road
Lookout Mountain, GA 30750

YES **NO** **(circle one)**

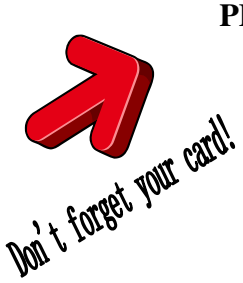
If you cannot see Dr. Smith, what primary physician in the Chattanooga area can you see?

_____

Name Phone number

Student Signature: _____ Date: _____

PLEASE COMPLETE THIS FORM AND ATTACH A LEGIBLE COPY (FRONT & BACK) OF YOUR CURRENT INSURANCE CARD.



If your insurance coverage changes again before next January, please stop by Health Services to complete a new form.

Return to:

Priesthill Center
Covenant College Health Services

Notice of Health Information Practices

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

Please read and sign the RECEIPT & RELEASE (only) return to Health Services.

Introduction

At Covenant College Priesthill Health Services, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Priesthill Center-Covenant College Health Services, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of Priesthill Center-Covenant College Health Services, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Priesthill Center-Covenant College Health Services is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact the practice's Privacy Officer, Tina Holt at 706-419-1275.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

PRIESTHILL CENTER

Covenant College Health & Counseling Services

PATIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides patient protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of patient records ("privacy rules"), and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. This Patient Notification of Privacy Rights is our attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document, as it is important you know what patient protections HIPAA affords all of us. In health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find we make every effort to do all we can to protect the privacy of your health care records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask for further clarification.

By law, Priesthill Center Health & Counseling Services is required to secure your signature indicating you have received this Patient Notification of Privacy Rights document. Thank you for your thoughtful consideration of these matters.

Tina Holt, FNP-C
Director of Health Services
HIPAA Compliance Officer

I, _____ , understand and have been informed by my health care provider of the Patient Notification of Privacy Rights document which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand that I have the right to review this document before signing this "acknowledgment form" and am doing so now**.**

_____ _____
Patient Signature or Parent if Minor or Legal Charge Date

If Legal Charge, describe representative authority:
_____

_____ _____
Witness Date

PRIESTHILL CENTER

Covenant College Health & Counseling Services

Release of Medical Information Form:

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) and other federal privacy regulations, students who are legal adults (age 18 or older) must approve any release of medical information by Health Services. No medical information may be released to parents, spouses or any other person, except for those individuals specified in the release below. These acts do not make any exception for children who are legal adults but are still tax dependents.

I, _____, hereby instruct Covenant College Health Services to release my medical information to the following people: (such as parents)

Names Relationship to you

_____
_____
_____
_____
_____

Signature: _____ Date: _____

Covenant College, Health Services, 14049 Scenic Highway, Lookout Mountain, Georgia 30750
Phone: (706) 419-1275, Fax: (706) 820-2933