HIGH POINT UNIVERSITY

HEALTH INFORMATION AND IMMUNIZATION FORM

Student Health by Cornerstone Healthcare
833 Montileu Ave, Campus Box 50
High Point, NC 27262
Telephone: 336-841-4683 • Fax: 336-841-4693 • studenthealth@highpoint.edu

REQUIRED FORMS: Due July 1st

Please keep a copy of these forms for future reference

❑ Immunization Form:

North Carolina Law GS 130z 152-157 requires all persons attending college to submit proper immunization records. If the immunization requirements are not met, registration for classes will be cancelled.

❑ Authorization and Consent Form:

Allows treatment in emergency situations, and should be signed by parent if student is not 18 years or older.

ADDITIONAL INFORMATION:

Our goal at High Point University Student Health is to provide extraordinary health care services for each student. In order to help us do so, please review the following list and send any or all of the information listed below. The following information will become part of the medical chart and is kept strictly confidential.

❑ Medical Records reviewing chronic medical conditions or current medications

❑ Copy of Health Insurance Card and/or Prescription Card (front and back)

❑ Signed HIPAA form

GUIDELINES FOR COMPLETING THE IMMUNIZATION RECORD

IMPORTANT: The immunization requirements must be met according to NC law (NC Law G.S. 130a – 152 - 157).
Be certain that your Name, Date of Birth, and ID Number appear on each sheet and that all forms are mailed together. The records must be in black ink and the dates of vaccine administration must include the month, day, and the year.

Please Keep a Copy for Your Records.

Acceptable Records of your Immunizations may be obtained from any of the following:

- Personal Shot Records – Must be verified by a provider's stamp or signature and include address of clinic or health department.
- High School Records – These may contain some, but not all of your immunization information. Your immunization records do not transfer automatically. You must request a copy.
- Local Health Department
- Military Records or WHO (World Health Organization) Documents – These records may not contain all of the required immunizations.
- Previous College or University Records – Your immunization records do not transfer automatically. You must request a copy.

SECTION A: COLLEGE/UNIVERSITY VACCINES AND NUMBER OF DOSES REQUIREMENTS

(for further information: immunize.nc.gov/schools/collegesuniversities)

VACCINE REQUIRED REVIEW ALL FOOTNOTES BELOW	Diphtheria, Tetanus, and/or Pertussis1	Polio2	Measles3	Mumps4	Rubella5	Hepatitis B6
Doses Required	3	3	2	2	1	3

Footnote 1 – 3 doses of tetanus, diphtheria toxoid, one of which must have been within the last 10 years. Those individuals enrolling in college or university for the first time on or after July 1, 2008 must have had three doses of tetanus/diphtheria toxoid and a booster dose of tetanus/diphtheria/pertussis vaccine if a tetanus/diphtheria toxoid or tetanus/diphtheria/pertussis vaccine has not been administered within the past 10 years.

Footnote 2 – An individual attending school who has attained his or her 18th birthday is not required to receive polio vaccine.

Footnote 3 – Measles vaccines are not required if any of the following occur: Physician diagnosis of disease prior to January 1, 1994; An individual who has been documented by serological testing to have a protective antibody titer against measles and submits the lab report; or An individual born prior to 1957. An individual who enrolled in college or university for the first time before July 1, 1994 is not required to have a second dose of measles vaccine.

Footnote 4 – Mumps vaccine is not required if any of the following occur: An individual who has been documented by serological testing to have a protective antibody titer against mumps and submits the lab report; An individual born prior to 1957; or Enrolled in college or university for the first time before July 1, 1994. An individual entering college or university prior to July 1, 2008 is not required to receive a second dose of mumps vaccine.

Footnote 5 – Rubella vaccine is not required if any of the following occur: 50 years of age or older; Enrolled in college or university before February 1, 1989 and after their 30th birthday; An individual who has been documented by serological testing to have a protective antibody titer against rubella and submits the lab report.

Footnote 6 – Hepatitis B vaccine is not required if any of the following occur: Born before July 1, 1994.

INTERNATIONAL STUDENTS and/or non-US Citizens: Vaccines are required as noted above. Additionally, these students are required to have a TB test that has been administered and read within the past 12 months. (Chest x-ray is required if test is positive).

SECTION B: RECOMMENDED VACCINES

These vaccines are RECOMMENDED. Some may be required by certain departments. Consult your college or department for specific requirements.

SECTION C: OPTIONAL VACCINES

These vaccines are optional.

IMMUNIZATIONS	**To be completed and signed by physician or clinic**		
Last Name	First Name	Middle Name	Date of Birth (mo/day/year)

SECTION A: REQUIRED IMMUNIZATIONS

	mo/day/year	mo/day/year	mo/day/year	mo/day/year
DPT or Td (series of 3)				
Tdap booster				
Td booster				
Polio				
MMR (after first birthday – 2 doses)				
Measles (after first birthday) Attach titer reports			Disease date:	Titer date & Result:
Mumps (after first birthday) Attach titer reports			Disease date NOT Accepted	Titer date & Result:
Rubella (after first birthday) Attach titer reports			Disease date NOT Accepted	Titer date & Result:
Hepatitis B (required if born 7/1/94 or after)				

SECTION B: RECOMMENDED IMMUNIZATIONS – The following immunizations are recommended for all students and may be required by certain colleges or departments (i.e., health sciences). Please consult with your college or department for specific requirements.

	mo/day/year	mo/day/year	mo/day/year	mo/day/year
Meningococcal (specify type)			Disease date:	Titer date & Result
Varicella (chicken pox) (series of two)				Attach lab report
Tuberculin (PPD) Test (within 12 months) Date read _________ / ___mm induration				
Chest X-ray (if positive PPD) Treatment (if abnormal Chest X-ray)	Date:___________ Result: __________ Date:___________ (Attach Physician's Documentation/Note)			

SECTION C: OPTIONAL IMMUNIZATIONS

	mo/day/year	mo/day/year	mo/day/year	mo/day/year
Pneumococcal				
Hepatitis A				
HPV (Gardasil)				
Other				

Signature and Clinic Stamp REQUIRED:	
Signature of Physician/Physician Assistant/Nurse Practitioner	Date
Print Name of Physician/Physician Assistant/Nurse Practitioner	(Area Code) Phone Number
Office Address:	

MENINGOCOCCAL DISEASE (MENINGITIS) AND VACCINE INFORMATION

Meningococcal disease is caused by bacteria called Neisseria meningitides. This bacterium is spread from person to person through respiratory secretions. Some individuals can be infected with the bacteria and yet exhibit no symptoms. They are unaware of the infection, yet can spread it to others. Others who are exposed to these bacteria will get significant infections, sometimes resulting in death. If the bacteria invades the bloodstream or other body tissues it can cause meningitis (inflammation of the membranes surrounding the brain and spinal cord), sepsis (infection of the blood stream), pneumonia (infection of the lungs), or pharyngitis (sore throat).

Studies show that freshmen entering college and residing in residential halls are at an increased risk of meningococcal disease relative to other persons of similar age. Due to this, it is recommended by the Center for Disease Control (CDC) that this vaccine is offered for other college students wanting to reduce their risk of this disease.

The vaccinations available that prevent this infection provide protection against serotypes A, C, Y and W- 135. They do not contain live bacteria. They are 85 – 100% effective in preventing disease from serotypes found in the vaccine, but they do not protect against the serotype B.

More information about the disease and the vaccines can be found at **www.immunize.nc.gov/family/vaccines/meningococcald.htm** or at **www.cdc.gov/meningitis/about/faq.html**.

NC Session Law 2003-194, HB 825 requires that any private or public institution with a residential campus offering postsecondary degrees “shall provide vaccination information on meningococcal disease to each student”.

High Point University recommends that students discuss this vaccination with their primary care provider.
High Point University Student Health Center by Cornerstone Health Care has the vaccine available.

To be completed by student

Last Name (Print)	First Name	Middle Name	DOB
Permanent Address	City	State Zip Code	(Area Code) Phone Number
Email Address			Student Cell Phone Number

HPU ID# ____________________	Gender ❑ M ❑ F	Marital Status ❑ S ❑ M ❑ Other
Class you are entering (circle): FR. So. JR. SR. GRAD.	Previously enrolled here ❑ Yes ❑ No	Semester Entering (circle): FALL SPRING Summer 1 Summer 2 Other Year 20_____

Health Insurance (Name and address of company) (Area Code) Phone Number

*Please attach copy of Insurance Card (Front and Back)

Name of Policy Holder (Subscriber)____________________ Date of Birth of Subscriber____________________

Policy/Cerificate #____________________

Group #____________________

AUTHORIZATION AND CONSENT FORM

Statement by student or parent/guardian (if student is under age 18):

(A) I have personally provided the above information (see checklist), 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 or other legal requirements. However, if I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission for Student Health Services by Cornerstone Health Care to release information from my (son/daughter's) medical record to any physician, hospital, or other medical agency involved in providing my (son/daughter's) emergency treatment and/or medical care.

(B) I hereby authorize any medical treatment for myself (my son/daughter) that may be advised or recommended by the medical providers of HPU Student Health Services by Cornerstone Health Care.

(C) I am aware that Student Health Services by Cornerstone Health Care charges for some services and I may be billed through HPU Student Accounts. I accept personal responsibility for settling the account with HPU Student Accounts for incurred charges. I am responsible for filing my personal patient charges, **incurred from on site services**, with my insurance, and acknowledge that my responsibility to High Point University is unaffected by the existence of insurance coverage. (I am also aware that certain testing may be sent to outside facilities, including Cornerstone Lab, along with proof of medical insurance coverage. I give permission to HPU Student Health Services by Cornerstone Health Care to coordinate filing any outside medical charges directly to my medical insurance plan. I accept personal responsibility for any co-pays, deductibles, or non-covered services that may apply.)

Signature of Student____________________ Date ____________

Signature of Parent/Guardian, if student is under age 18 ____________________ Date ____________

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STUDENT HEALTH SERVICES BY CORNERSTONE HEALTH CARE

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HIPAA CONSENT FORM

Please Print:
Student (Patient) Name: ____
(Last) (First) (Middle Initial)

HPU ID #: ____

Social Security Number: ______________________________ Date of Birth: ______________

Student (patient) information will be maintained by Student Health Services as described by our *Notice of Privacy Practices*, and in compliance with federal and state regulation. You may obtain a copy of the *Notice of Privacy Practices* at any time from Student Health Services or directly from our website, www.highpoint.edu.

Student Health Services reserves the right to release your health information based upon a decision by your medical provider here for medical emergency situations and in general for continuity of care. We may release your healthcare information to third-party payers in order to receive payment for billable services. We will use your healthcare information as needed to maintain our internal operations. We will release your information to anyone else that you may elect in writing to receive it.

We reserve the right to:
- Call you to relay lab/test result information and leave information on your answering machine to contact our facility.
- Contact you for potential research that might benefit your well-being.

Other than the above mentioned release, your personal healthcare information will NOT be released to others, including your parent(s), unless listed below.

Indicated by checking below, I give permission to provide information to the following:

❑ Parent/Guardian: ____
(Full Name) (Telephone #)

❑ HPU Athletic Training Staff and/or Program Director **(*FOR ATHLETES ONLY*)**
(Athletic Trainers/Program Directors **will** be notified based upon the ***Athletic HIPAA Consent*** already on file if today's visit is in regards to an athletic injury, or any other condition/illness which may impact your training or participation as an athlete, with or without checking this box. Otherwise, if you do not check this box, we will **only** notify the training staff that you were seen at Student Health, but no health information will be released.)

❑ Other(s) (Name/Telephone #): ____

____

Student (Patient) Signature: ____

Witness Signature: ____
(Any individual over the age of 18 who is present to witness the patient/student signature)

Today's Date: ____________________

(HIPAA Consent to be renewed annually, or at any other time when requested by the student)