

STUDENT HEALTH FORM

The College requires students to have a medical history form on file at the Student Health & Wellness Center prior to matriculation. This information is confidential and will not influence your standing at Champlain College. **DEADLINES:** Students admitted for August—**form is due July 01.** / Students admitted for January—**form is due December 15.**

SECTION ONE — HEALTH HISTORY

INFORMATION ABOUT YOURSELF

Name: [first / middle / last] _____

Today's Date: [mm / dd / yyyy] _____ Date of Enrollment: [mm / yyyy] _____

Date of Birth: [mm / dd / yyyy] _____

Male Female Transgender _____

Commuter Resident Transfer

Home Phone: [xxx.xxx.xxxx] _____ Cell Phone: [xxx.xxx.xxxx] _____

Email: _____

Permanent Address: _____ Apt #: _____

City: _____ State/Province: _____ ZIP/Postal Code: _____

Country: _____

Health Insurance: _____

Emergency Contact: _____ Relationship: _____

Home Phone: [xxx.xxx.xxxx] _____ Cell Phone: [xxx.xxx.xxxx] _____

Address: _____ Apt #: _____

City: _____ State/Province: _____ ZIP/Postal Code: _____

Country: _____

List any chronic illness you have or have had in the past (such as asthma, diabetes, depression, learning disability, ADHD, or substance abuse):

List any medications you take daily or as needed: _____

List any medications that have caused an abnormal reaction:

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

List any hospitalization, surgery or procedures (such as a tonsillectomy) you have had, including dates:

SECTION ONE — HEALTH HISTORY (continued)

PERSONAL HEALTH HISTORY

YES	NO	COMMENTS / DATES OF ILLNESS
<input type="checkbox"/>	<input type="checkbox"/>	ADHD: _____
<input type="checkbox"/>	<input type="checkbox"/>	Allergies _____
<input type="checkbox"/>	<input type="checkbox"/>	Anorexia/Bulimia _____
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety _____
<input type="checkbox"/>	<input type="checkbox"/>	Asperger's _____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma _____
<input type="checkbox"/>	<input type="checkbox"/>	Autism _____
<input type="checkbox"/>	<input type="checkbox"/>	Back Problem _____
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder _____
<input type="checkbox"/>	<input type="checkbox"/>	Breast Pain or Abnormality _____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer _____
<input type="checkbox"/>	<input type="checkbox"/>	Chickenpox _____
<input type="checkbox"/>	<input type="checkbox"/>	Concussion _____
<input type="checkbox"/>	<input type="checkbox"/>	Consumption of Alcohol _____
<input type="checkbox"/>	<input type="checkbox"/>	Depression/Counseling _____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes _____
<input type="checkbox"/>	<input type="checkbox"/>	Drug Usage _____
<input type="checkbox"/>	<input type="checkbox"/>	Ear Infections (frequent) _____
<input type="checkbox"/>	<input type="checkbox"/>	Eye Problems _____
<input type="checkbox"/>	<input type="checkbox"/>	Gynecologic Concerns _____
<input type="checkbox"/>	<input type="checkbox"/>	Headache/Migraines (frequent) _____
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss _____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur or Problem _____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis _____
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure/High Cholesterol _____
<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS _____
<input type="checkbox"/>	<input type="checkbox"/>	Joint or Limb Problems _____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems _____

YES	NO	COMMENTS / DATES OF ILLNESS
<input type="checkbox"/>	<input type="checkbox"/>	Learning Disability _____
<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Problems _____
<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis _____
<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia _____
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic/Scarlet Fever _____
<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis _____
<input type="checkbox"/>	<input type="checkbox"/>	Seizure/Fainting _____
<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Infection _____
<input type="checkbox"/>	<input type="checkbox"/>	Skin Problem (acne, eczema) _____
<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Bowel Problem _____
<input type="checkbox"/>	<input type="checkbox"/>	Testes/Scrotum Problem _____
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problem _____
<input type="checkbox"/>	<input type="checkbox"/>	Underweight/Overweight _____
<input type="checkbox"/>	<input type="checkbox"/>	Urinary Tract Infections _____
<input type="checkbox"/>	<input type="checkbox"/>	Use of Tobacco Products _____
<input type="checkbox"/>	<input type="checkbox"/>	Other Mental Health Concerns _____
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

FAMILY HEALTH HISTORY

<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Abuse _____
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder _____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer _____
<input type="checkbox"/>	<input type="checkbox"/>	Depression _____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes _____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease/High Blood Pressure _____
<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol _____
<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headaches _____
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease _____

Student's Name: [first / middle / last] _____

Date of Birth: [mm / dd / yyyy] _____

SECTION TWO — IMMUNIZATION HISTORY (section to be completed by student)

An accurate immunization history is required of all new students regardless of age. This document must be signed by a health care professional and returned in order for the student to register for classes. Alternatively, you may supply an official immunization record as provided by your health care provider. All dates must include month/day/year.

VERMONT STATE LAW requires that all full-time and part-time students born after 1956 who are enrolled in post-secondary schools to have all of the following immunizations. Proof of these immunizations must be kept on file in the Student Health & Wellness Center. As of July 1, 2016, the State of Vermont does not allow for philosophical exemption for required vaccinations.

Student's Name: [first / middle / last] _____

Date of Birth: [mm / dd / yyyy] _____ Date of Enrollment: [mm / yyyy] _____

Student's Signature: _____ Date: [mm / dd / yyyy] _____

TO BE COMPLETED & SIGNED BY A HEALTH CARE PROVIDER (section to be completed by health care provider)

VACCINES	DATES GIVEN [mm / dd / yyyy]	REQUIREMENTS
Tdap or Td	<input type="checkbox"/> Tdap <input type="checkbox"/> Td Date 1 _____	1 Tdap/Td booster within last 10 years
MMR	Date 1 _____ Date 2 _____ OR Positive Titer Dates: Measles _____ Mumps _____ Rubella _____	2 doses or positive titers Minimum of 4 weeks between doses First dose given after 1st birthday
Meningococcal (Menactra)	Living in campus-based housing? <input type="checkbox"/> Yes <input type="checkbox"/> No Date 1 _____ Date 2 _____	Students living in campus-based housing must have at least one dose of meningitis vaccine covering types ACWY after their 16th birthday , even if two doses were received prior to their 16th birthday. Vaccination for meningitis B is recommended but not required.
Varicella (Chicken Pox)	1. Immunizations: Date 1 _____ Date 2 _____ OR Positive Titer Date: _____ 2. History of disease? <input type="checkbox"/> Yes (complete page 6) <input type="checkbox"/> No	2 doses of varicella vaccine or history of disease or positive titer Minimum of 4 weeks between doses if age 13 or older (12 weeks for under age 13)
Hepatitis B	Date 1 _____ Date 2 _____ Date 3 _____ OR Positive Titer Date: _____	3 doses or positive titer Minimum of 4 weeks between doses 1 and 2 Minimum of 8 weeks between doses 2 and 3 (third dose must be 16 weeks from first dose)

Health Care Provider's Signature: _____ Phone: [xxx.xxx.xxxx] _____

Health Care Provider's Name: [printed] _____ Date: [mm / dd / yyyy] _____

Health Care Provider's Address: _____

City: _____ State/Province: _____ ZIP/Postal Code: _____

Country: _____

continued >>

SECTION THREE — PRIVACY NOTICE & CONSENT TO TREAT

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW YOUR HEALTH RECORDS MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THESE RECORDS. PLEASE REVIEW IT CAREFULLY. This privacy notice is being provided to you as a patient of the Student Health & Wellness Center (the "Center" or "we"). This privacy notice is designed to describe how your health records that we acquire while you are a patient at the Center may be used or disclosed.

SERVICES PROVIDED

The Center provides healthcare to Champlain College's undergraduate and international students and referral services for graduate students. Our staff includes nurse practitioners, registered nurses and administrative support. In addition to providing individualized care to students, we also teach health education and wellness on a one-on-one basis and through campus-wide programming. Our focus is on independent care of acute and chronic conditions that affect the student population. We are not a primary care provider and do ask that our students maintain a relationship with their primary care provider.

CONFIDENTIALITY

The Center is committed to your right to privacy and maintaining the confidentiality of your health records. The Center staff operates as a team in order to provide the best possible service to students. As professionals, we confer with each other within the Center and, to the extent you receive services from the Counseling & Accommodations Center, we will confer with professionals providing counseling services. The Center may also disclose your treatment records to healthcare providers outside of Champlain College that are involved in your care.

Information will not be disclosed outside of the center without your written permission, except as provided below. When information is disclosed, it becomes subject to the recipient's privacy policies and may be disclosed in ways not allowed or anticipated by these policies, including to insurance companies or other payers.

EXCEPTIONS TO WRITTEN CONSENT

The Center may disclose your treatment records without your consent as permitted or required by law, including in the following situations:

- **Other Health Providers Involved in Your Treatment:** The Center may disclose treatment records to other health care providers with whom we are collaborating on your treatment plan. This includes providers we are referring you to for specialty and/or emergency care, including Champlain College Counseling & Accommodations Center and University of Vermont Medical Center.
- **Public Health Authorities:** The Center must report any instance where a student patient has a communicable disease that is listed on the Department of Health's website as a threat to the public.
- **Judicial Order, Subpoena and Legal Action:** We may disclose your treatment records in order to comply with a judicial order or lawfully issued subpoena. We will make a reasonable effort to notify you of the order or subpoena in advance of compliance with the request, so you may seek protective action. If a legal dispute should arise between you and us, we may disclose your health records to the court, without a court order or subpoena, as long as the information is relevant for us to either defend ourselves or proceed as the plaintiff.
- **Firearm Wound and Child Abuse:** The Center is required to report student patients that present with firearm wounds to the authorities. Clinic staff are also required to report reasonable suspicions of child abuse, either in an underage student or in the children of students.

QUESTIONS OR COMPLAINTS

You are encouraged to ask questions regarding our confidentiality policy. If you have any questions or complaints, please contact the Center.

continued >>

SECTION THREE — PRIVACY NOTICE & CONSENT TO TREAT (continued)

CONSENT TO TREAT

My signature below indicates that:

- I have read the above Privacy Notice
- I consent to treatment by the Champlain College Student Health & Wellness Center staff
- I authorize the Center to contact my health care provider about any information missing from my health history or immunization record
- If I require specialist services, lab testing, x-rays, prescriptions or other referrals beyond the primary care services available at the Center, I shall assume the financial responsibility in collaboration with my health insurance provider

Student's Signature: _____ Date: [mm / dd / yyyy] _____

Student's Name: [printed] _____ DOB: [mm / dd / yyyy] _____

Parent/Legal Guardian Signature: [if student is under 18] _____ Date: [mm / dd / yyyy] _____

EMAIL COMMUNICATIONS

We prefer to not communicate with patients via email due to potential security risks. The best way to communicate with us and maintain the privacy of your confidential information is to speak with us in person or on the phone. If you desire to have us communicate with you by email, we prefer to have your consent in advance.

I consent to the Student Health & Wellness Center communicating with me about my confidential health information via email and acknowledge and accept the risks of communicating my sensitive health information by email.

Student's Signature: _____ Date: [mm / dd / yyyy] _____

Student's Name: [printed] _____ DOB: [mm / dd / yyyy] _____

Parent/Legal Guardian Signature: [if student is under 18] _____ Date: [mm / dd / yyyy] _____

continued >>

SECTION FOUR — DOCUMENTATION OF VARICELLA IMMUNIZATION

**Documentation of Varicella
(Chickenpox) Disease**



Vermont's School Immunization Regulations apply to students in attendance at any public or independent kindergarten, any elementary or secondary school and certain post-secondary schools. Before school entry, students must have the required immunizations, including 2 doses of varicella (chickenpox) vaccine. However, students who have had chickenpox disease can still enroll provided this form be completed, signed and provided to the school. Please note that this form does not need to be signed by a physician or other health care provider. **RETURN THIS FORM TO THE STUDENT'S SCHOOL.**

This document is being submitted on behalf of the following student:

Name:

_____ Last

_____ First

Date of Birth :

____/____/____

I _____ verify that the above listed student
Parent/Guardian/Self (18 and over)

had varicella (chickenpox) disease in ____/____.
Month Year

Signature of parent or guardian of student or student 18 and over

____/____/____
Date

RETURN THIS FORM TO THE STUDENT'S SCHOOL

**The Vermont Department of Health
Immunization Program
108 Cherry Street P.O. Box 70
Burlington, Vermont 05402**

**802-863-7638 or
1-800-464-4343 ext. 7638
healthvermont.gov**