CHAMPLAIN COLLEGE

Student Health Center, P.O. Box 670, Burlington, VT 05402
Phone 802.860.2711 | Fax 802.860.2761

STUDENT HEALTH FORM

The College requires students to have a medical history form on file at the Student Health 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/Providence: ________ ZIP/Postal Code: ________

Country: ______________________________

Health Insurance: ______________________________

Emergency Contact: ______________________________ Relationship: ______________

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

Address: ______________________________ Apt #: ________

City: ______________ State/Providence: ________ 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:

____

____

continued >>

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SECTION ONE — HEALTH HISTORY (continued)

PERSONAL HEALTH HISTORY

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

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

FAMILY HEALTH HISTORY

YES	NO	COMMENTS
☐	☐	Alcohol Abuse ______
☐	☐	Bleeding Disorder ______
☐	☐	Cancer ______
☐	☐	Depression ______
☐	☐	Diabetes ______
☐	☐	Heart Disease/High Blood Pressure ______
☐	☐	High Cholesterol ______
☐	☐	Migraine Headaches ______
☐	☐	Thyroid Disease ______

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

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

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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	☐ Tdap ☐ 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? ☐ Yes ☐ 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? ☐ Yes (complete page 6) ☐ 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/Providence: ________ ZIP/Postal Code: ________

Country: ____________________

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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.

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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] ____________

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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

Documentation of Varicella Disease 2.8.2008

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