

# LENOIR~RHYNE UNIVERSITY

## STUDENT HEALTH SERVICES

### Student Health Record

*Return to:*

Student Health Center LR

Box 7399

Hickory, NC 28603 or

Fax: 828-328-7348 or

[Studenthealth.records@lr.edu](mailto:Studenthealth.records@lr.edu)

[dynamicforms.ngwebsolutions.com](http://dynamicforms.ngwebsolutions.com)

Please read carefully and complete the following forms. Incomplete forms may delay your ability to register for classes or move onto the LR campus. **Note the due date for the immunization record is different from the other forms.** If you have any questions or need assistance, please contact Student Health Services office: 828-328-7959; or email: [studenthealth.records@lr.edu](mailto:studenthealth.records@lr.edu); confidential fax: 828-328-7348. **Welcome to LR!**

- **Immunization Record** (pages 2-6 of the Student Health Record) North Carolina Law (G.S. 130A-155.1) requires persons attending a college or university, whether public or private to present a Certificate of Immunization or record of immunization prior to registering for classes unless the student meets the exemptions (see page 2).

**ALL Students must complete page 5.**

*Due May 1st for Summer and Fall Enrollment*

*Due December 1<sup>st</sup> Spring Enrollment*

- **Student Health History/Physical** (pages 7-15 of the Student Health Record)

**ALL Undergraduate and Health Care-Based Graduate Students must complete pages 7-15.**

*Due July 15 for Fall Enrollment Due*

*May 15 for Summer Enrollment Due*

*January 1 for Spring Enrollment*

Required for *ALL*:

**Full-time Undergraduate Students**

**Athletes – Including Intramural/Club/NCAA sports**

**Nursing (Undergraduate and FNP/DNP Only)**

**Occupational Therapy**

**Dietetic Intern**

*An attached copy of a physical examination is acceptable as long as the exam addresses all aspects of the LR physical examination and CANNOT be more than a year old before the first day of class. **NCAA Athletes must have an updated physical.***

## Guidelines for Completing Immunization Record

ATTENTION: According to North Carolina law, proof of immunization must be submitted prior to registering for classes.

**You are ONLY exempt from submission of Immunization Records (pg. 4) if ANY of the below apply to you. If you do not check any of the boxes below, proceed to page 4.**

Check all that apply (without immersions):

- Graduate students enrolled in all online courses (**Students enrolled in the Dietetic Internship and FNP/DNP programs will need to complete the full student health record**).
- Students taking only 4 or less credit hours.
- Students enrolled in evening classes (after 5pm) only.
- Students enrolled in weekend classes only.
- Graduate students enrolled in classes at the Center for Graduate Studies of Asheville campus (**Students enrolled in undergraduate programs & the Dietetic Internship Program will need to complete the full health record**).
- Graduate students enrolled in classes at the Lutheran Theological Southern Seminary (LTSS) or in the Clinical Mental Health Counseling/Human Services programs at the Center for Graduate Studies of Columbia campus. (**Students enrolled in the Occupational Therapy program will need to complete the full health record**).

**If you checked any of the above boxes you are exempt from having to submit immunizations. Please sign below and return this page with Page 5 of the Student Health Record (TB Questionnaire).**

### EXEMPT STUDENT'S SIGNATURE

I meet one of the above exemptions (please check the appropriate exemption(s)). I understand that if anytime during my enrollment at Lenoir-Rhyne University I no longer meet the exemption status, I will be required to submit my immunization record. I will have **14 days** after my status change to submit the records.

\_\_\_\_\_  
Print Student's Name

\_\_\_\_\_  
Signature of Student (or Parent/Legal Guardian if  
The student is under 18 years of age)

\_\_\_\_\_  
Date

## Guidelines for Completing Immunization Record

*(Take this page with you to your physician if you do not have official documentation for pages 4-6 and/or need to receive an immunization)*

**Section A (pg. 4); required by NC state law:** Please note: your age as of June 15th (for Fall enrollment) and January 1st (for Spring & Summer enrollment).

### **Students born after July 1, 1994:**

- 3 DTP, TD, Tdap or Tdap doses. **NOTE:** one TD or Tdap dose must have been within the last **10** years. **If you are due for a dose; a Tdap is required.**
- 3 oral polio doses.
- 2 measles, 2 mumps, and 1 rubella (MMR) doses or lab documented serological testing/titer proving immunity signed by your physician. Measles exemption if physician documented diagnosis of disease diagnosis prior to January 1, 1994.
- 3 Hepatitis B if born **AFTER** July 1, 1994, **or** are a Nursing (Traditional, RIBN, and NP/DNP) OT, Dietetic Intern..
- 1 varicella immunization or titer showing immunity **or** are a Nursing (Traditional, RIBN, and NP/DNP) OT or Dietetic Intern..

### **Students born 1957 or later and has attained his/her 18th birthday:**

- 3 DTP, TD, Tdap or Tdap doses. **NOTE:** one TD or Tdap dose must have been within the last **10** years. **If you are due for a dose a Tdap is required.**
- 2 measles, 2 mumps, and 1 rubella (MMR) doses or lab documented serological testing/titer proving immunity signed by your physician. **NOTE:** Measles exemption if physician documented diagnosis of disease diagnosis prior to January 1, 1994. If you enrolled in college/university for the 1<sup>st</sup> time prior to July 1, 1994, you only have to provide 1 dose of measles vaccine. Rubella exemption if 50 years of age or older or enrolled in college/university after the age of 30 before February 1, 1989. If you enrolled in college/university for the 1<sup>st</sup> time prior to July 1, 2008 you only have to provide 1 dose of mumps vaccine.

### **Students born before 1957:**

- 3 DTP, TD, Tdap or Tdap doses. **NOTE:** one TD or Tdap dose must have been within the last **10** years. **If you are due for a dose a Tdap is required.**

### **Section B (pg. 5) :**

- **ALL** students must complete this questionnaire. If you answer “**yes**” to any of the questions or if you are a Dietetic Intern student you **must** have a TB skin test (PPD/Mantoux) prior to starting classes.
- **ALL** International students are required to have the TB skin test (PPD/Mantoux)
- **ALL** Nursing (undergraduate, and NP/DNP),and OT students are required to have a PPD/Mantoux.

**Section C (pg. 6):** Optional but recommended for all other students.

**Lenoir-Rhyne University Student Immunization Record:** Legible copies of acceptable official immunization records may be submitted. Acceptable records are: High School Transcripts, personal shot records with physician's signature and clinic stamp/letterhead, military record, health department records, medical office records with physician's signature or letterhead/clinic stamp, or previously attended college/university records.

*(If attaching an acceptable copy of Immunization Records, please write "See Attached" on this page)*

Please **CIRCLE** if any applies to you: **Nursing (undergraduate, RIBN, and FNP/DNP), Occupational Therapy, Student, Dietetic Intern, or NCAA Athlete (List Your Sport):**

\_\_\_\_\_  
Last Name                      First Name                      Middle Name                      Date of Birth

| <b>Section A: Required Immunizations</b>   |                     |                     |   |
|--|---------------------|---------------------|---|
|  | Month / Date / Year | Month / Date / Year | Month / Date / Year                               |
| 2 doses of DPT, or DTap or TD or TDAP & at least one TD or TDAP in the last 10 years             | #1                  | #2                  | #3 (This date has to be within the last 10 years) |
| Polio  | #1                  | #2                  | #3  |
| Measles  | #1                  | #2                  | Or Serological testing / titer test results       |
| Mumps  | #1                  | #2                  | Or Serological testing / titer test results       |
| Rubella  | #1                  | #2                  | Or Serological testing / titer test results       |
| Hepatitis B ( <i>required if born after July 1<sup>st</sup> 1994 or if Nursing, OT or, DI.</i> ) | #1                  | #2                  | #3  |
| Varicella (Chicken Pox) <i>Note: Disease date not acceptable; Titer or Vaccine dates only</i>    | #1                  | #2                  | Or Serological testing / titer test results       |

|   |               |
|---|---------------|
| Signature of Physician / Physician Assistant / NP:  | Date:         |
| Print Name of Physician / Physician Assistant / NP: | Phone Number: |
| Clinic Stamp:                                       |               |

**\*\*\*ALL STUDENTS MUST TURN IN THIS PAGE – NO EXCEPTIONS!\*\*\***

Please **CIRCLE** if any applies to you: **Nursing (undergraduate FNP/DNP) Occupational Therapy, Dietetic Intern, or NCAA Athlete (List Your Sport):** \_\_\_\_\_

\_\_\_\_\_  
 Last Name                      First Name                      Middle Name                      Date of Birth

| <b>Section B: Tuberculosis (TB) Exposure Questionnaire – ALL students must complete!</b>   |            |           |
|--|------------|-----------|
| <i>**ALL International students must have the TB skin test (PPD/Mantoux)**</i>   |            |           |
| <i>**ALL Occupational Therapy students must complete two-step TB skin test (PPD/Mantoux)**</i>   |            |           |
| <i>Note: BCG Vaccination does not exempt TB skin testing</i>   |            |           |
|  | <b>YES</b> | <b>NO</b> |
| Have you experienced any of the following symptoms: unexplained weight loss, loss of appetite, night sweats, fever, fatigue, cough lasting longer than 3 weeks, chest pain, or hemoptysis (coughing up blood)?   |            |           |
| Have you ever been diagnosed with TB?  |            |           |
| Do you have HIV?   |            |           |
| Have you been in contact with a person who has TB?   |            |           |
| Do you inject illicit drugs?   |            |           |
| Have you resided in, been employed by, or volunteered in: prison, jail, long term care facility, nursing home, hospital, and other health care facilities, residential facilities for persons with AIDS or homeless shelters?  |            |           |
| Do you have ANY of the following conditions: silicosis, diabetes, chronic renal failure, hematological disorders, malignancies, 10% or more below your ideal weight, history of gastrectomy or jejunioileal bypass, prolonged corticosteroid therapy, immunosuppressive therapy, pulmonary fibrotic lesions visible on a chest x – ray from prior untreated TB or any other immunosuppressive disease? |            |           |
| Have you visited (including cruise port stops) or resided in a country of high TB prevalence within the last 5 years: Asia, Africa, Caribbean, Latin America, Mexico, South America, Pacific Islands or Eastern Europe   |            |           |

If you answered **YES** to any of the above questions; **OR** you are an International student, **OR** you are a Dietetic Intern, you **MUST** have a TB (PPD/Mantoux) skin test.

*\*\*If you have had a TB skin test within the last 12 months, those results are acceptable as well. However, if you have traveled to the above countries since that prior test, you must have a new TB skin test administered.\*\**

Tuberculin (TB) Test Results:

|  |                     |  |
|--|---------------------|--|
| Date Placed:                             | Date Read:          | Result: (Circle One)      Positive      Negative<br>Induration: _____ mm<br>Clinic Stamp or Signature Below: |
| Date of Chest X-Ray for Positive Result: | Chest X-Ray Result: | Treatment Date:<br>(Provide copy of Physician's treatment orders/notes)                                      |

Please **CIRCLE** if any applies to you: **Nursing (undergraduate, RIBN, FNP/DNP), Occupational Therapy, Dietetic Intern, or NCAA Athlete (List Your Sport):** \_\_\_\_\_

\_\_\_\_\_  
 Last Name                      First Name                      Middle Name                      Date of Birth

| <b>Section C: Optional Vaccines for ALL Students</b>  |                   |                   |                   |                   |
|---|-------------------|-------------------|-------------------|-------------------|
|   | Month / Date / Yr |
| Haemophilus Influenza Type B  |                   |                   |                   |                   |
| Pneumococcal  |                   |                   |                   |                   |
| Hepatitis A   |                   |                   |                   |                   |
| Gardasil  |                   |                   |                   |                   |
| Typhoid (Specify Type):   |                   |                   |                   |                   |
| Meningococcal   |                   |                   |                   |                   |
| COVID<br>(check one)<br><input type="checkbox"/> Moderna<br><input type="checkbox"/> Pfizer<br><input type="checkbox"/> Johnson & Johnson |                   |                   |                   |                   |
| Other (Specify):  |                   |                   |                   |                   |

|   |               |
|---|---------------|
| Signature of Physician / Physician Assistant / NP:  | Date:         |
| Print Name of Physician / Physician Assistant / NP: | Phone Number: |
| Office Address and/or Clinic Stamp:                 |               |

## Medical Release

A) I have personally reviewed and provided all required student health information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and guarded according to HIPAA and/or FERPA laws. However, if I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission for LR to release the information from my (son/daughter's) medical record to a physician, hospital, or other medical agency involved in providing me (him/her) with 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 LR Student Health Center. Medical treatment providers include but are not limited to the LR Student Health Provider, LR Athletic Trainers, LR emergency responders, Physicians, Hospitals, and any other medical services deemed necessary by the LR Student Health Provider

C) I understand that services in the LR Student Health Center are provided at no cost to the student. However, if referred to a physician there will be billable services. Catawba Valley Medical Group (Provider and referral group for students referred off campus) files insurance as a courtesy for students. I acknowledge that I (or my parent) am responsible for co-pays at the time of services and any unpaid balance after insurance payment.

\_\_\_\_\_  
Print Student's Name

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Legal Guardian (if student is under 18 years old.)

\_\_\_\_\_  
Print Parent/Legal Guardian's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
 Last Name                      First Name                      Middle Name                      Date of Birth

\_\_\_\_\_  
 Home Address                      City                      State                      Zip Code  
 (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_

Home Phone Number                      Student's Cell Number                      Student's Email Address

Have you previously attended LR?                       Yes  No                      If yes, what year \_\_\_\_\_

|   |   |   |                                       |
|---|---|---|---------------------------------------|
| <b>Semester Entering:</b><br>Fall   Spring   Summer | <b>Class:</b><br>FR   SO   JR   SR   GRAD | <b>Status:</b><br>Full Time   Part Time | <b>Living on Campus?:</b><br>Yes   No |
|---|---|---|---------------------------------------|

**Emergency Contact Information:** (Provide 2)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Numbers: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Numbers: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**Health Insurance Information:** (Please include a Front/Back copy of Insurance Card)

I do not have health insurance

\_\_\_\_\_  
 Policyholder/Subscriber's Name                      Relationship                      Date of Birth

\_\_\_\_\_  
 Name of Insurance Company                      Policy/Certificate #                      Group #

Is this: PPO     HMO     Managed Care

I have confirmed with my insurance company that I am covered in NC to see a doctor or urgent care facility for healthcare services; excluding emergencies:    Yes     No

*NOTE: If your insurance policy requires pre-approvals, referrals, in-network physicians, or other special policy terms, it is your responsibility to clarify and know this information.*

**Do you have a Healthcare Power of Attorney?**    Yes  (If yes, submit a copy)    No

**Do you have a Living Will?**    Yes  (If yes, submit a copy)    No

Last Name                      First Name                      Middle Name                      Date of Birth

**Personal and Family Health History: Completed by Student and/or Parent**

*All information provided is confidential, does not affect your admission and, except in an emergency situation, will not be released without your written permission.*

**Does anyone; related to you by *blood* currently have and/or previously had:**

|                            | Yes | No | Relationship: |                        | Yes | No | Relationship: |
|----------------------------|-----|----|---------------|------------------------|-----|----|---------------|
| Sudden Death before age 55 |     |    |               | Blood/Clotting Disease |     |    |               |
| Stroke                     |     |    |               | Heart Attack           |     |    |               |
| Sickle Cell                |     |    |               | High Blood Pressure    |     |    |               |
| Cholesterol Disorders      |     |    |               | Other Heart Disease    |     |    |               |
| Diabetes                   |     |    |               | Glaucoma               |     |    |               |
| Gout                       |     |    |               | Epilepsy               |     |    |               |
| Cancer (type)              |     |    |               | Alcohol/Drug Addiction |     |    |               |
| Psychiatric Illness        |     |    |               | Suicide                |     |    |               |

**Do you have or have you ever had: (If yes, please indicate the YEAR only of your first occurrence)**

|                                   | Yes | No | When: |                                 | Yes | No | When: |
|-----------------------------------|-----|----|-------|---------------------------------|-----|----|-------|
| Abnormal Bleeding/Bruising        |     |    |       | Heart Disease/Murmur            |     |    |       |
| ADD/ADHD                          |     |    |       | Headaches (Severe/Recurrent)    |     |    |       |
| AIDS/HIV Positive                 |     |    |       | Hernia                          |     |    |       |
| Autism                            |     |    |       | High Blood Pressure             |     |    |       |
| Allergy Injection/Shots Therapy   |     |    |       | Hearing Loss                    |     |    |       |
| Amnesia                           |     |    |       | Heat Related Illness            |     |    |       |
| Anemia or Sickle Cell Anemia      |     |    |       | Head Injury                     |     |    |       |
| Anorexia / Bulimia                |     |    |       | Irregular Periods/Menstruation  |     |    |       |
| Anxiety / Panic Attacks           |     |    |       | Intestinal Disease/Disorder     |     |    |       |
| Appendicitis                      |     |    |       | Irritable Bowel Syndrome        |     |    |       |
| Arthritis                         |     |    |       | Jaundice                        |     |    |       |
| Asthma                            |     |    |       | Joint dislocations/Inflammation |     |    |       |
| Back Injury / Pain                |     |    |       | Joint/Bone deformity            |     |    |       |
| Birth Defect                      |     |    |       | Kidney Stones                   |     |    |       |
| Bipolar Disorder                  |     |    |       | Kidney Infection                |     |    |       |
| Bladder / Urinary Tract Infection |     |    |       | Kidney Disease                  |     |    |       |
| Blood Clots / DVT                 |     |    |       | Kidney Injury                   |     |    |       |
| Blood Transfusion                 |     |    |       | Meningitis                      |     |    |       |
| Broken Bones (Specify)            |     |    |       | Migraine (Diagnosed by MD)      |     |    |       |
| Bronchitis                        |     |    |       | Mononucleosis                   |     |    |       |
| Cancer (Type)                     |     |    |       | Mumps                           |     |    |       |
| Chicken Pox                       |     |    |       | Measles                         |     |    |       |
| Cigarette Use                     |     |    |       | Malaria                         |     |    |       |
| Concussion                        |     |    |       | Mental Health Counseling        |     |    |       |
| Depression                        |     |    |       | Muscular Disease                |     |    |       |
| Diabetes (Specify Type)           |     |    |       | Motion Sickness                 |     |    |       |
| Dizzy / Fainting Spells           |     |    |       | Mouth Sores                     |     |    |       |
| Drug Use / Dependency             |     |    |       | Nosebleeds                      |     |    |       |
| Epilepsy                          |     |    |       | Neck Injury                     |     |    |       |
| Gastrointestinal Disease/Disorder |     |    |       | Pain/Pressure in Chest          |     |    |       |
| Gallbladder Disease /Gallstones   |     |    |       | Pericarditis                    |     |    |       |
| Gout                              |     |    |       | Pneumonia                       |     |    |       |

|                                   |  |  |  |                                 |  |  |  |
|-----------------------------------|--|--|--|---------------------------------|--|--|--|
| Polio                             |  |  |  | Narcolepsy                      |  |  |  |
| Pain (chronic) Where?             |  |  |  | Recurrent Respiratory Infection |  |  |  |
| Paralysis                         |  |  |  | Rheumatic Fever/Heart Disease   |  |  |  |
| Recurrent Abdominal Pain          |  |  |  | Ruptured Organs                 |  |  |  |
| Radiation/Chemotherapy            |  |  |  | Rectal Bleeding/Disease         |  |  |  |
| Rubella                           |  |  |  | Recurrent Vomiting / Diarrhea   |  |  |  |
| Recurrent Sinusitis/Infection     |  |  |  | Stomach Ulcer                   |  |  |  |
| Seizures (include last date)      |  |  |  | Sexually Transmitted Disease    |  |  |  |
| Skin Diseases                     |  |  |  | Skin Allergies                  |  |  |  |
| Shortness of Breath               |  |  |  | Tumor/Growth/Cyst               |  |  |  |
| Thyroid Disease                   |  |  |  | Ulcer, Intestinal               |  |  |  |
| Urinary Infections/Blood in Urine |  |  |  | Other (Specify)                 |  |  |  |

### Allergy History:

Do you have (If yes, check):

- Medication Allergies: \_\_\_\_\_
- Food Allergies: \_\_\_\_\_
- Other Allergies: \_\_\_\_\_
- Anaphylactic Allergies: \_\_\_\_\_
- An Epi-Pen (include Expiration date): \_\_\_\_\_
- I have NO known drug, food, or any other allergies

### Medication History:

Please list all current medications you are taking:

\_\_\_\_\_

\_\_\_\_\_

### Additional Medical History:

Do/Have you:

|   | Yes | No |   | Yes | No |
|---|-----|----|---|-----|----|
| Wear glasses/contacts                                     |     |    | Wear hearing aids (Right/ Left / Both)  |     |    |
| Had Pins, Staples, Rods or Wires in your Body             |     |    | Had any type of Shunt                   |     |    |
| Had Heart Implantation Devices                            |     |    | Had treatment for Sleeping Difficulties |     |    |
| Had an Echocardiogram                                     |     |    | Drink Alcohol? (How often)              |     |    |
| Had a Heart/Cardiac Stress Test                           |     |    | Have any false teeth? Orthodontia?      |     |    |
| Have/Had Ear Tubes  |     |    | Had any reactions to Anesthesia?        |     |    |
| Spent the night in a Hospital (Specify Why/When):         |     |    | List all operations: (Type/Year)        |     |    |
| Currently under the care of a Physician (Specify MD Name) |     |    | Other: (Explain)                        |     |    |



|                     |  |  |  |
|---------------------|--|--|--|
| Genitourinary       |  |  |  |
| Metabolic/Endocrine |  |  |  |
| Neuropsychiatric    |  |  |  |
| Mammary             |  |  |  |
| Gastrointestinal    |  |  |  |
| Other (Specify)     |  |  |  |

|           |            |             |               |
|-----------|------------|-------------|---------------|
| Last Name | First Name | Middle Name | Date of Birth |
|-----------|------------|-------------|---------------|

A. Is there loss or seriously impaired function of any paired organs?    Yes     No

B. Is student under treatment for any medical or emotional condition?    Yes     No

C. Is the student physically healthy?    Yes     No

D. Is the student emotionally healthy?    Yes     No

E. Cleared for Participation

Based on my review of the patient questionnaire and my physical assessment, this student is presently physically and emotionally qualified to participate in: (check all items that student is cleared for below):

Lenoir-Rhyne / NCAA Athletics

Physical Education Classes

Intramural / Club Sports

Travel Abroad Programs

Volunteer Service Programs

FNP/DNP Program

\*\*If student is not cleared, please explain: \_\_\_\_\_

|   |               |
|---|---------------|
| Signature of Physician/Physician's Assistant/NP:  | Date:         |
|   |               |
| Print Name of Physician/Physician's Assistant/NP: | Phone Number: |
|   |               |
| Office Address and/or Clinic Stamp:               |               |
|   |               |

# LENOIR~RHYNE UNIVERSITY

## Student Health Information Disclosure/Release

Privacy Laws (HIPAA) prevents the Student Health Center from releasing any information to all persons other than the student unless permission has been granted by the student. Please check the appropriate boxes.

I, (print full name) \_\_\_\_\_ hereby authorize the staff of the Lenoir Rhyne Student Health Services Center to release the following information (choose all that apply):

- Specific information on visit to Health Center (reason for visit, diagnosis, etc.)
- Immunization Information
- Insurance Information
- ALL information in my LR Student Health Center medical record
- Messages may be left on my cell phone
- Messages may be left on my home phone
- I am **not** designating release of information to anyone but myself

This information may be released to (name and relationship):

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I understand that I may change this release only in person and in writing at any time. This disclosure will remain active the during the student's entire LR enrollment unless otherwise changed.

Student's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Legal Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_  
(If student is under age 18 years of age)



## **Cornerstone Student Support and Wellness Center**

### **Informed Consent**

#### **Disability, Health, and Counseling Services are Working Together with You**

The Cornerstone Student Support and Wellness Center (CSSWC) at Lenoir-Rhyne University offers current students an array of services. Students may meet with the school nurse practitioner, and utilize disability services, as needed. In addition, all current LR students may receive one-on-one individual counseling.

The service providers in the CSSWC operate as a clinical team. Given the close relationship between the psychological and the biological (learning disabilities, medication evaluation, etc.), we often work collaboratively. As a client of the CSSWC, you are entitled to receive information about the methods and duration of treatment, techniques used, fee structure, and associated risks, if known. Treatment is an active and cooperative effort involving both you and your care providers. If you should have any concerns about your progress or the results of your treatment, we encourage you to discuss them with us at any time. You can terminate treatment at any time.

#### **Confidentiality**

Counseling and health services often involve the disclosure of personal information. State laws and professional ethical codes dictate that the information discussed during these sessions will be strictly confidential, if you are 18 years of age or older. Your health and mental health records are not kept as part of your academic or administrative records. Furthermore, we cannot and will not disclose to anyone what we discuss in session, or that you are even receiving services, without your written permission.

#### **Exceptions: The following are legal exceptions to your right to confidentiality.**

**Harm to self:** If there is evidence that an individual poses clear and imminent danger of harming themselves, the provider may have to notify the hospital, school officials, law enforcement, and/or family members who may be able to assist with the matter.

**Harm to others:** If there is reason to believe that you will harm another person, the provider must attempt to inform the intended victim, school officials, as well as law enforcement.

**Child/ Elder Abuse or neglect:** Providers who know or reasonably suspect that a child under the age of 18 is being abused and/or neglected are legally obligated to report this information to the appropriate state agencies. This also applies in cases of elder abuse and/or neglect.

**Court order:** If your records are ordered by the court of law, the provider will do what they can to protect confidentiality-within the limits of abiding by the law.

**Staff consultation and supervision of trainees:** To protect your privacy within the center, we follow a “need to know” guideline. This means that providers may review your records if they are treating you for concerns that may be related to care you have received at the CSSWC. Additionally, providers may work collaboratively to provide you with the best treatment possible.

Some services are offered by staff that are supervised by licensed clinicians. In order to ensure the highest standards of care, supervised clinicians meet with their supervisors weekly and review the progress of their work with you. The limits of confidentiality delineated in this Consumer Rights statement apply to this supervision. Supervisors have responsibility for the work of their supervised therapists and are available for consultation upon your request. If you have any questions about this supervisory relationship, we encourage you to talk with your care provider. Additionally, at times, your counselors may audio or videotape the session to consult with other professional staff or receive supervision from a clinical supervisor. Your participation in audio/videotaping is strictly confidential. Should you choose to participate your written permission would be required.

*I authorize my health care provider to discuss my treatment with other treating professionals of The Cornerstone Student Support and Wellness Center staff, Lenoir-Rhyne University, when indicated. I have had the opportunity to discuss this informed consent statement with my provider and I understand its meaning and consent to receiving treatment. I understand that should it be determined that discussions with individuals not directly involved in my treatment would be beneficial to me (i.e. parents, friends) written consent will be requested, unless such disclosures are permitted by law without my written consent.*

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**Print Name**

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**Student ID**

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**Signature**

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**Date**