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

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; 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 1st 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 15th for Fall Enrollment
  Due May 15th for Summer Enrollment
  Due January 1st 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 1st 1994.
- 3 Hepatitis B if born AFTER July 1st 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..
- 1 Meningococcal or titer showing immunity
- COVID vaccine 1 and 2 (or J & J 1) and booster

Students born after 1957 but before 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**.
- 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 1st time prior to July 1, 1994, you only have to provide 1 dose of measles vaccine. Rubella exemption if 50 years of age of older or enrolled in college/university after the age of 30 before February 1, 1989. If you enrolled in college/university for the 1st time prior to July 1, 2008 you only have to provide 1 dose of mumps vaccine.
- COVID vaccine 1 and 2 (or J & J 1) and booster

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**.
- COVID vaccine 1 and 2 (or J & J 1) and booster

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

Section A: Required Immunizations			
	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 Seological testing/titer test results
Meningococcal	#1		
Hepatitis B (*required if born after July 1st 1994 or if Nursing, OT or, DI.*	#1	#2	#3
Varicella (Chicken Pox) *Note: Disease date not acceptable; Titer or Vaccine dates only*	#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

Section B: Tuberculosis (TB) Exposure Questionnaire – ***ALL students must complete!***
ALL International students must have the TB skin test (PPD/Mantoux)*
ALL Occupational Therapy students must complete two-step TB skin test (PPD/Mantoux)
Note: BCG Vaccination does not exempt TB skin testing

	YES	NO
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 jejunoileal 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 Induration: _____ mm Clinic Stamp or Signature Below:
Date of Chest X-Ray for Positive Result:	Chest X-Ray Result:	Treatment Date: (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

Section C: Optional Vaccines for *ALL* Students				
	Month / Date / Yr	Month / Date / Yr	Month / Date / Yr	Month / Date / Yr
Haemophilus Influenza Type B				
Pneumococcal				
Hepatitis A				
Gardasil				
Typhoid (Specify Type):				
COVID □ Moderna □ Phizer □ Johnson & Johnson				Booster
Other (Specify)				

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

CATAWBA VALLEY MEDICAL GROUP - PATIENT REGISTRATION – CATAWBA VALLEY FAMILY HEALTH CENTERS – LRU

PATIENT INFORMATION: DATE_____/_____/_____

NAME: LAST_____ FIRST _____ MIDDLE INITIAL _____

CIRCLE ONE: MR. MRS. MISS. MS. JR. NICKNAME OR PREVIOUS NAME: _____ (IF APPLICABLE)

DATE OF BIRTH ____/____/____ **SEX** □ F □ M □Unknown □Transgender **SOCIAL SECURITY #** ____ / ____ / ____
MAILING ADDRESS _____

STREET ADDRESS (IF DIFFERENT FROM MAILING)
_____

CITY _____ STATE _____ ZIP_____ HOME PHONE (_____) _____ - _____

CELL PHONE (____) ____ - _____WORK PHONE (____) ____ - _____ PRIMARY CARE PROVIDER: _____

APPOINTMENT AND HEALTH REMINDERS:

Is it okay to leave a message regarding your appointment reminder? □ **Yes** □ **No**

Please choose ONE option for your appointment reminder communication:
□ **Phone** Preferred Phone: _____ Preferred time: □ Morning □ Afternoon □ Evening
□ **Text** Preferred Phone: _____ Preferred time: □ Morning □ Afternoon □ Evening
May we leave a message to have you return our call with family, friends, or on an answering machine at:
HOME □ **Yes** □ **No** **CELL** □ **Yes** □ **No** **WORK** □ **Yes** □ **No**

I can STOP text reminders at any time by contacting my practice directly and requesting that text appointment reminders to be turned off
Please check any or all the following options to give us permission to send you important health reminders via:
□ Email- emails will be sent to the email address you provide in the 'Web Enable/ Patient Portal Access' section of this Form □ Letter

RESPONSIBLE PARTY: (Responsible party is the person financially responsible for the patient statement/bills)

□ SELF □ GUARANTOR - RELATIONSHIP TO PATIENT _____(Complete below if different than "Patient Information" above)

NAME_____ ADDRESS _____

CITY_____ STATE _____ ZIP_____ HOME PHONE (_____) _____ - _____

DOB_____/_____/_____ SOCIAL SECURITY # _____ / _____ / _____ SEX □ F □ M

EMPLOYER NAME _____ ADDRESS _____

MARITAL STATUS: □ SINGLE □ DIVORCED □ LEGALLY SEPARATED □ PARTNER
□ MARRIED (SPOUSE NAME _____) □ WIDOWED □ UNKNOWN

EMPLOYMENT STATUS:

DEPARTMENT NAME_____ □ FULL TIME □ PART TIME

ADVANCE DIRECTIVE: Do you have a Living Will or an Advance Directives document? Please check all that apply

□ NO □ DNR (Do Not Resuscitate) □ POA (Power of Attorney) □ Living Will

If not, our staff will be glad to provide you with information. If you have already signed a living will or advanced directive form, please submit a copy to this office for our records.
□ I wish to receive Advanced Directive Information □ FOR CLINIC USE ONLY: Information given to Patient

Due to our participation in Federal Healthcare Programs, we are required to collect the following information:

Sexual Orientation: Do you think of yourself as: □ Straight or heterosexual □ Lesbian, gay or homosexual □ Bisexual □Something else □Don't know □Choose not to answer

What is your current gender identity (Check one): □ Male □ Female □ Transgender Male/Trans Man/ Female-to-Male (FTM)

□ Transgender Female/ Trans Woman/ Male-to-Female (MTF) □ Genderqueer, neither exclusively male nor female

□ Additional Gender Category/ (or Other), please specify: _____

□ Choose not to answer

What sex were you assigned at birth on your original birth certificate? (Check one): □ Male □ Female □ Choose not to answer

How does patient want to be addressed? □ He/Him □ She/ Her □ They/Them □ Choose not to answer □ Other:_____

□ I do not wish to receive Advanced Directive Information

WEB ENABLE/PATIENT PORTAL ACCESS

If you would like to access your Personal Health Record (PHR) online, please check yes below and provide us with your email address. By providing your email address we will also be able to send you a patient satisfaction survey after your visit.

□ **Yes** □ **No** **Email Address:** _____

RACE: _____ ETHNICITY: □ HISPANIC □ NON-HISPANIC

INTERPRETATION SERVICES NEEDED? _____ IF SO, WHAT LANGUAGE OR SERVICE: _____

PHARMACY (RETAIL):

NAME _____

ADDRESS / LOCATION _____

PHONE (_____) _____ - _____

FAX (_____) _____ - _____

PHARMACY (MAIL ORDER):

NAME _____

ADDRESS / LOCATION _____

PHONE (_____) _____ - _____

FAX (_____) _____ - _____

MAIL ORDER UNIQUE MEMBER ID #

PRESCRIPTION REFILLS:

I understand that Catawba Valley Medical Group may need to access my refill information at all of my pharmacies regarding the prescriptions that I have had filled. □ **Yes** □ **No**

PATIENT EDUCATIONAL NEEDS:

How do you learn best? Please Circle or explain in the area labeled "Other" how we can best serve you.

(Circle one): Hearing information or reading information? Other: Please List. _____

EMERGENCY CONTACT: **Authorized to release medical information to Emergency Contact?** □ **Yes** □ **No**

NAME: LAST_____ FIRST _____ RELATIONSHIP TO PATIENT_____

ADDRESS_____ CITY _____ STATE _____ ZIP _____

HOME PHONE (_____) _____ - _____ WORK PHONE (_____) _____ - _____ EXT. _____

MOBILE/CELL PHONE: (_____) _____ - _____

CONSENT TO TREAT A MINOR:

If patient is a minor, can patient receive medical care without a parent/guardian being present? □ YES □ NO
If patient is a minor, who can authorize medical care other than a parent/guardian, please list: _____
If patient is a minor, parent sign here for permission to treat in your absence:

_____
Parent Signature Date

AUTHORIZATION TO RELEASE INFORMATION TO: (example: spouse, child, or caregiver)

Name	Phone	Relationship to Patient

PLEASE LIST ANY IMMEDIATE FAMILY MEMBERS WHO ARE PATIENTS: (You may list more than one family member)

Name	Phone	Address	Relationship to Patient

Consent to medical treatment: I voluntarily consent to such diagnostic procedures and care deemed necessary by the physician, his or her assistant or designated consultants. I understand the practice of medicine and surgery is not an exact science and I further acknowledge that no guarantees have been made to me as to the result of examination or treatment in this clinic.

Conditions of clinical and financial services: Your insurance will be automatically filed as a courtesy to you. Please be sure to provide a copy of your insurance card to staff. Insurance co-pays and unmet deductibles are due at time of service. I understand and acknowledge that I am liable for all charges designated my responsibility that is not paid by insurance.

***Authorization to release information*:** I hereby authorize my provider to release all information pertaining to my treatment to my insurance company or companies and to any other physician or health care provider to whom I may be referred. I hereby authorize regulatory and accrediting agencies to review my medical record during surveys or inspections. In an effort to improve my care, CVMG is participating in a health information exchange, which is a secure electronic database of patient information contributed by participating hospitals and providers. My medical information will be contributed to the health information exchange unless I choose not to participate or to "opt out".

Assignment of benefits: I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicaid, private insurance, and other health plans to: Catawba Valley Medical Group.

Notice of privacy practices: My signature below acknowledges that I have been given the opportunity to receive a full disclosure of the privacy practices as outlined by the health insurance portability and accountability act of 1996.

Personal Valuables: I understand that CVMC/CVMG is not responsible for personal valuables brought into the practice or left in my vehicle.

Recording or Filming: Recording or Filming (to include photographs, video, electronic or audio media): I understand that from time to time Catawba Valley Medical Group (CVMG) may record or film me while care is being provided (for example, photo documentation of injuries). I understand that these recordings/films/photos will only be viewed internally for identification purposes; for the treatment, diagnosis or evaluation of my care; or for internal organizational use to assist in maintaining or improving quality of care and to educate medical staff.

I have read the Consent to Medical Treatment, Financial Information and other information above.
I understand and agree to its terms.

(PATIENT SIGNATURE)

(DATE)

RESPONSIBLE PARTY SIGNATURE) (RELATIONSHIP)

(DATE)

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)		

Last Name First Name Middle Name Date of Birth

Physical Examination: *(Must be completed by licensed physician, physician's assistant or NP)* **An attached copy of a physical examination is acceptable as long as the exam addresses all aspects of the LR physical and cannot be more than a year old prior to the first day of class.** ***A physical must be on file if you live on campus, or to be treated in the Student Health Center on the Hickory Campus (for undergraduate students).*

Height _____ Weight _____ Blood Pressure _____

Vital Signs: Temperature, Pulse, Respirations _____

Vision: Corrected Right: 20/___ Left: 20/ ___ Uncorrected Right: 20/___ Left: 20/ ___ Color Vision Impairment? Yes No	Hearing: Are there any known impairments? If so, please explain: _____ _____
Labs (If indicated): Urinalysis: Sugar _____ Micro _____ Albumin _____	If Indicated or a history of Blood Disorders: Hemoglobin: _____ Hematocrit: _____

ALL NCAA/LR Athletes (Per NCAA Bylaw):

Sickle Cell Solubility Test Performed (Or attach copy of previous test results):

Test Result: Positive for Sickle Cell Negative for Sickle Cell

Physician's Signature: _____ Date: _____

Assessment	Normal	Abnormal	Explanation/Description (Attach additional sheet if necessary)
Head and Neck			
Ears, Nose and Throat			
Eyes			
Respiratory			
Cardiovascular			
Musculoskeletal			
Skin			
Hernia			

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

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.

_____ _____

Print Name **Student ID**

_____ _____

Signature **Date**