LENOIR-RHYNE UNIVERSITY

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 LRU 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 LRU!!!!**

- **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 January 1st Spring Enrollment

- **Student Health History/Physical** (pages 7-13 of the Student Health Record)
  Due July 15th for Fall Enrollment
  Due May 15th for Summer Enrollment
  Due January 1st for Spring Enrollment

  - Pages 7 – 10 & 13 *(required for **ALL** Students unless you meet the Immunization Exemptions on page 2).*
  - Pages 11 and 12/ Physical Examination (*You must have a physical on file to be treated in the LRU Student Health Center).*
    Required for ***ALL***:
    Residential Students
    Athletes – Including Intramural/Club/NCAA sports
    Nursing (Undergraduate and RIBN Only)
    Athletic Training
    Occupational Therapy
    Dietetic Intern
    Physician Assistant

An attached copy of a physical examination is acceptable as long as the exam addresses all aspects of the LRU 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 submitting 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:

- ○ I am enrolling in online classes only (Graduate Students Only).
- ○ I am taking only 4 or less credit hours.
- ○ I am enrolling in evening classes (after 5pm) only.
- ○ I am enrolling in weekend classes only.
- ○ I am only enrolled in classes at the Center for Graduate Studies of Asheville campus.
- ○ I am only enrolled in classes at the Lutheran Theological Southern Seminary (LTSS), Columbia SC campus.

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 DOCUMENTATION OF IMMUNIZATION RECORDS

(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 May 1st (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 or RIBN), AT, OT, Dietetic Intern, PA student.
- 1 varicella immunization or titer showing immunity **or** are a Nursing (Traditional or RIBN),AT, OT, Dietetic Intern, or PA student.

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 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.

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, OT, and PA students are required to have a PPD/Mantoux.

Section C (pg. 6): These vaccines are **required** for All Dietetic Intern, Nursing, Occupational Therapy, Physician Assistant & Athletic Training programs. And are optional but recommended for all other students.

Section D (pg. 6): These vaccines are optional for all 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, Athletic Training, Occupational Therapy, Physician Assistant 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 Serological testing / titer test results
Hepatitis B (*required if born after July 1st 1994 or if Nursing, AT, OT, DI, or PA*)	#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:	

Please **CIRCLE** if any applies to you: **Nursing, Athletic Training, Occupational Therapy, Physician Assistant Student, 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)**** *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.

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

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, Athletic Training, Occupational Therapy, Physician Assistant Student, 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):				
Meningococcal *(Highly recommended, required of PA)*				
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 LRU 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 LRU Student Health Center. Medical treatment providers include but are not limited to the LRU Student Health Nurse, LRU Athletic Trainers, LRU emergency responders, Physicians, Hospitals, and any other medical services deemed necessary by the LRU Director of Student Health (or delegate).

C) I understand that services in the LRU Student Health Center are provided at no cost to the student. However, if referred to a physician there will be billable services. Hart Family Practice (Medical Director for the LRU Student Health Center) 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 LRU? Yes ☐ No ☐ If yes, what year _____

Semester Entering: Fall Spring Summer	**Class:** FR SO JR SR GRAD	**Status:** Full Time Part Time	**Living on Campus?** 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 emergences: 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)			

Medication 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

Please list all current medications you are taking (Prescription, over the counter, herbs, supplements, home remedies):

____

____

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 LRU physical and cannot be more than a year old prior to the first day of class. ***A physical must be on file to be treated in the Student Health Center)*

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/LRU 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

☐ Physician Assistant 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):

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

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

____
____
____
____
____

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 LRU enrollment unless otherwise changed.

Student's Signature________________________________ Date______________

Parent/Legal Guardian's Signature _____________________
(If student is under age 18 years of age) Date_____________

Cornerstone Student Support and Wellness Center

Informed Consent

Health and Counseling 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, utilize deaf and hard of hearing services as needed, and disability services. 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**