www.eastern.edu

Pre-Entrance Student Health Record

Attached are the **REQUIRED EU Health Forms** for **all first-year and transfer students.** The Health Center is committed to assuring your continued good health while you are a student at Eastern University.

1. **MEDICAL HISTORY/CONTACT INFORMATION FORM** – Medical History is to be completed by student and reviewed by Health Care Provider at physical exam appointment.

2. **PHYSICAL EXAM FORM** – to be completed, signed and dated by Health Care Provider
   - To be completed within one year prior to school entrance. ******After March 1st for athletes.

3. **IMMUNIZATION RECORD FORM** – to be signed and dated by Health Care Provider.
   - MMR - (Measles, Mumps, Rubella) – 2 Shot Series or proof of immunity via titer report
   - TETANUS – Must have been given within the past 10 years
   - HEPATITIS B – 3 Shot Series or proof of immunity via titer report
   - PPD Skin Test – *Administered within 12 months prior to school entrance*. (All International Students will receive a PPD test upon arrival to EU.) If the result is positive, a follow-up chest x-ray or blood test will be required.
   - MENINGOCOCCAL - Required for all students residing in campus housing (or signed waiver)
   - MENINGOCOCCAL B
   - POLIO - (IPV or OPV) - Last date in 3 or 4 shot series
   - VARICELLA - (Chicken Pox) – 2 shot series or date of disease or proof of immunity via titer report

4. **INSURANCE INFORMATION** – Photocopy of *front* and *back* of health insurance card
5. **HIPAA RIGHT OF ACCESS FORM** - To be completed and signed (page 6 of 12)
6. **ACKNOWLEDGMENT OF RECEIPT OF HIPAA DISCLOSURE AND NOTICE OF PRIVACY PRACTICES -** To be completed and signed (page 7 of 12)
7. **HIPAA DISCLOSURE AND NOTICE OF PRIVACY PRACTICES** - *For your information* (pages 8-12*)*

****IMPORTANT: All Health Forms are to be completed and submitted to the STUDENT HEALTH CENTER on or before JUNE 1st.**

Students should make a copy of their health forms in the event they are required for the Athletic Department and other extra-curricular activities.

Damona Wilson, Nurse Director
EU Student Health Services
1300 Eagle Road
St. Davids, PA 19087

Phone: (610) 341-5974
Fax: (610) 341-5954

EASTERN UNIVERSITY

SPRING FALL 20___

1300 Eagle Road, St. Davids, PA 19087-3696 **Circle Spring or Fall Session**

LAST NAME (Print)	FIRST NAME	M.I.	BIRTH DATE	SCHOOL ID#

FULL PERMANENT ADDRESS	HOME PHONE	CELL PHONE

MEDICAL HISTORY/CONTACT FORM

Medical History & Injury Questionnaire – ***to be completed by student/student-athlete***

Social History

Marital Status: __ Single __ Married __ Separated __ Divorced
Living with: __ Parents __ Legal Guardian __ Spouse
No. of Siblings: __ Brothers __ Sisters

Family Medical History

Have any of your relatives ever had any of the following medical conditions? Please list the family member.

	Yes	No	Family Member		Yes	No	Family Member		Yes	No	Family Member
Cancer	__	__	_____	Asthma	__	__	_____	High Blood Pressure	__	__	_____
Tuberculosis	__	__	_____	Stroke	__	__	_____	Marfan's Syndrome	__	__	_____
Diabetes	__	__	_____	Arthritis	__	__	_____	Epilepsy/Seizures	__	__	_____
Kidney Disease	__	__	_____	Heart Attack	__	__	_____	Sudden Death	__	__	_____
Heart Disease	__	__	_____	Stomach Ulcers	__	__	_____	(While playing Athletics or during exertion)			

Personal Medical History

Have you ever had, or do you now have, the following? If you are unsure, please ask your physician. Indicate by marking YES or NO to all of the following medical conditions.

	Yes	No		Yes	No		Yes	No
ADD/ADHD	__	__	Epilepsy	__	__	Migraine Headaches	__	__
Allergies (Food)	__	__	Fainting Spells	__	__	Mumps	__	__
Allergies (Medicine)	__	__	Fibromyalgia	__	__	Pleurisy	__	__
Allergies (Seasonal)	__	__	Gout	__	__	Rheumatic Fever	__	__
Anemia	__	__	Headaches (Frequent)	__	__	Scarlet Fever	__	__
Anxiety	__	__	Heart - Murmur	__	__	Shortness of Breath	__	__
Appendicitis	__	__	Heart - Palpitations	__	__	***Sickle Cell Trait**	__	__
Arthritis	__	__	Hemorrhoids	__	__	Sinusitis	__	__
Asthma	__	__	Hepatitis	__	__	Skin Disorder	__	__
Back Trouble	__	__	Hernia	__	__	Spitting/Coughing Blood	__	__
Blood in Urine	__	__	High/Low Blood Pressure	__	__	Stomach (Ulcers, Gastritis, Reflux)	__	__
Cancer	__	__	History of Blood Clots	__	__	Tendency to Bleed Easily	__	__
Chest Pain	__	__	HIV/AIDS	__	__	Thyroid Trouble	__	__
Chicken Pox	__	__	Infectious Mononucleosis	__	__	Tonsillitis	__	__
Chronic Bronchitis	__	__	Kidney Disease	__	__	Tuberculosis	__	__
Convulsions	__	__	Kidney Stones	__	__	Venereal Disease	__	__
Depression	__	__	Measles	__	__	Weakness, Paralysis	__	__
Diabetes	__	__	Meningitis	__	__	Whooping Cough	__	__
Eating Disorder	__	__	Mental Illness	__	__	(Women) Atypical Menses	__	__

***Intercollegiate Athletes – if you answered yes to SCT, please complete SCT form provided by Athletic Department.**

MEDICAL HISTORY (Continued)

LAST NAME (Print)	FIRST NAME	M.I.	DATE OF BIRTH

Have you ever tested positive for COVID-19? _____ If yes, when?_____

Were you hospitalized? _____

Please explain any responses marked YES on previous page. Include month/year and outcome if applicable.

Emergency Contact Information

In order of preference, please list up to 3 people whom we can contact in case of emergency:

Name	Relationship	Work phone	Cell phone
1.			
2.			
3.			

EASTERN UNIVERSITY

PHYSICAL EXAM FORM

Physical Examination – ***To be completed by Health Care Provider***

Student/Student-Athlete Name: _____ Date: _____

Date of Birth: _____ Age: _____ Male: ☐ Female: ☐

Height: _____ Vision: R _____/_____ L _____/_____

Weight: _____ Contact Lenses? Yes No

Pulse: _____ Blood Pressure: _____

Medical Examination

	OK	Problem	Comment
Eyes/Fundus			
Ears, Nose, Throat			
Mouth & Teeth			
Head & Neck			
Skin & Scalp			
Lymphatics			
Cardiovascular, Heart			
Chest, Lungs			
Thorax			
Abdomen			
Hernia			
Genitalia			
Neurologic			

Orthopedic Examination

	OK	Problem	Comment
Neck			
Shoulders			
Elbow, Hand & Wrist			
Back, Spine			
Hips, Thighs			
Knees			
Ankles			
Feet			
Flexibility			

1. Please list all PRESCRIPTION MEDICATION you are currently taking:

Medication Name Medication Dosage Reason for taking

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

LAST NAME (Print) **FIRST NAME** **M.I.**

1. **Please list all OVER-THE-COUNTER MEDICATION you are currently taking:**

Medication Name	Medication Dosage	Reason for taking

2. **Please list all the NUTRITIONAL SUPPLEMENTS you are currently taking:**

Medication Name	LIST THE INGREDIENTS (you may attach a photo-copy of the label)

3. **Participation Recommendations**: ***Required for ALL STUDENTS*

____ Full Unlimited Participation
____ Limited Participation, i.e.: _____
____ Clearance Withheld Until: _____
____ No Athletic Participation

HEALTH CARE PROVIDER NAME (PLEASE PRINT)

ADDRESS: _____

PHONE: _____ FAX: _____

HEALTH CARE PROVIDER SIGNATURE: _____ Date: _____

****Signature acknowledges that the Health Care Provider has reviewed Medical History and completed Physical Exam.**

INSURANCE CARD -- ***PLEASE ATTACH COPY OF INSURANCE CARD BELOW (FRONT AND BACK)***

Front	**Back**

EASTERN UNIVERSITY

IMMUNIZATION RECORD

NAME: _____DOB:_____SCHOOL ID#_____

Note that the immunizations listed below are **REQUIRED.** Specify the medical or religious reason for any immunization that is not given. Documentation of immunity via **TITERS** is **ACCEPTABLE.**

A. M.M.R. (Measles, Mumps, Rubella) - TWO doses required.

Dates: # 1 ____/_____/_____ # 2 ____/_____/_____ ***OR TITERS WITH REPORTS***
Mo. Day Year Mo. Day Year

B. Tdap – (Tetanus, Diphtheria, Acellular Pertussis) - MUST be within the LAST 10 YEARS

Date: _____/ _____/_____
Mo. Day Year

C. HEPATITIS B - **THREE doses** of vaccine or a positive Hepatitis surface antibody

1. **Dates:** # 1 _____/_____/_____ # 2 ____/_____/_____ # 3 ____/_____/_____
Mo. Day Year Mo. Day Year Mo. Day Year

OR

2. **Hepatitis B Surface Antibody:** ***TITER WITH REPORT***

D. TUBERCULOSIS SCREENING - PPD within the last 12 months (required regardless of prior BCG inoculation)

1. PPD (Mantoux) **Date:** ____/ _____/_____ **Result:** _____ mm induration
Mo. Day Year
2. **If positive PPD,** then student may choose to have **either a chest x-ray or a Quanti Feron TB Gold blood test** performed. Copy of lab results is required. If you have completed INH therapy, please provide documentation.

E. MENINGOCOCCAL – Series of 2 OR 1 dose after age 16. (Required for all students residing in campus housing)

Dates: # 1 _____/_____/_____ # 2 ____/_____/_____
Mo. Day Year Mo. Day Year

F. MENINGOCOCCAL B

Dates: # 1 _____/_____/_____ # 2 ____/_____/_____
Mo. Day Year Mo. Day Year

G. POLIO:

Most Recent Booster Date: ____/_____/_____ ***OR TITER WITH REPORT***
Mo. Day Year

H. VARICELLA: (Either a history of Chicken Pox or TWO doses of the vaccine)

Dates: # 1 ____/_____/_____ # 2 ____/_____/_____ ***OR TITER WITH REPORT***
Mo. Day Year Mo. Day Year

****HEALTH CARE PROVIDER SIGNATURE: _____Date: _____**

HIPAA Right of Access Form

I, _____, direct my health care and medical services providers to disclose and release my Protected health information described below to:

_____ _____
Name of Contact Relationship

_____ _____
Cell Phone Home Phone

Health Information to be disclosed upon the request of the person named above (check either A or B):

____ **A. Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions).

____ **B. Disclose** my health record as above, **BUT do not disclose** the following (check request):

___ Mental health records ___ Communicable diseases (STI, HIV, etc.)

___ Alcohol/drug abuse & treatment ___ Pregnancy

____ Other (please specify) _____

_____

I understand that the health record(s) released by the facility/person authorized above may possibly be re-disclosed by the facility/person that receives the record(s) and therefore (1) its staff/employees have no responsibility or liability as a result of the re-disclosure and (2) such information would no longer be protected by the Privacy Rule.

This authorization shall be effective until (check one):

____ Transfer/Graduation from Eastern University

____ Date or event: _____unless I revoke it.

(NOTE: You may revoke this authorization, in writing, at any time by notifying the Student Health Center.)

I understand the following:

- That my decision to revoke this Authorization does not apply to any release of my health record(s) that may have taken place prior to the date of my request to revoke the Authorization.
- That my decision to revoke this Authorization may result in my insurance company not being able to pay for my medical claim, and I may be liable for payment of the claim.
- That I am entitled to a copy of this completed Authorization.

_____ _____ _____
Printed Name Birth Date Student ID

_____ _____
Signature of the Individual Giving this Authorization Date

****** I decline to release my PHI to anyone at this time. _____
Signature

Acknowledgment of Receipt Student Health Center HIPAA Disclosure and Notice of Privacy Practices

____ I understand and have been provided with the EU Student Health Center HIPAA Disclosure and Notice of Privacy Practices that provides a more complete description of medical information uses and disclosures.

____ I understand that I have the right to review the notice prior to signing this acknowledgement form.

____ I understand that the Student Health Center (SHC) reserves the right to change their notice and practices. That change will be posted in the office and available on the website.

____ I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that Eastern University is not required to agree to the restrictions requested.

____ I understand that I may revoke this acknowledgement in writing, except to the extent that the SHC has already taken action in the reliance thereon.

____ I understand this will be in effect as long as I am a student at Eastern University.

OR

____ I refuse a copy of the SHC HIPAA Disclosure and Notice of Privacy Practices.

_____ _____

Student Signature Date

_____ _____

Printed Name Refused/Initials

HIPAA DISCLOSURE

In compliance with the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160 and 164 (HIPAA) that protects patient confidentiality, Eastern University will not share health record information unless such sharing is permissible or required under law. Our Student Health Center staff considers the privacy of personal health information a priority. We collect and create student health files to use as records of care provided in the SHC. We use these records to assist in current or future student health treatment and management and for matters of compliance with immunization and disease control issues. We are able to provide continuity of care throughout a student's tenure at EU. The student is responsible for notifying his or her parents or guardian regarding any health issues. A member of our staff may notify parents in the event of an emergency. The policy is designed to maintain the confidentiality of the student, but also recognize the need for the parents or guardians to be adequately informed. Medical information regarding their son's or daughter's health status will not be available to parents without written permission from the student. Our staff will answer general medical questions, however confidentiality will be maintained.

Health care providers, health insurance companies and other health related agencies are required by State and Federal legislation to maintain privacy practices. Our SHC staff is trained on and held accountable for maintaining confidentiality. EU is required to:

- Maintain the privacy of the students' personal health information (PHI).
- Provide notice that describes our privacy practices.
- Follow the practices described in the notice.
- Obtain a written receipt from the student

We reserve the right to change our privacy practices at any time. New practices will be effective for all past, present and future health information we maintain. We will revise this notice periodically and make it available upon request.

Visit www.hhs.gov/hipaa for more information on HIPAA.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND HOW YOU MAY OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

The following describes the different ways the Eastern University SHC uses and discloses your PHI:

- **Treatment and services** – We may share your PHI with other physicians, nurses, and other health care personnel and agencies that provide, coordinate or manage your health care.
- **Payment** – We may use or disclose your PHI to obtain payment for services rendered. We forward private insurance charges to our Student Account Department. SHC charges will be itemized as Health Center Charges. We forward school insurance charges directly to the insurance company. A bill will be sent to you or your third party payer (insurance) for laboratory work done in the Health Center. Any information forwarded may include information that identifies you, as well as your diagnoses, procedures, health providers and supplies.
- **Health Center Operations –** We may use or disclose your PHI in order to run our department according to healthcare regulations. This will enable us to provide quality services. These activities may include insurance related transactions, quality assessment, reviewing the competence or qualifications of our staff, notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location and general condition, emails for appointment reminders, conducting medical reviews, legal services, audits, accreditations, certifications, licensing or credentialing activities, fraud and abuse detection.
- **Business Associates –** We may use or disclose your PHI for services not provided by the SHC such as emergency and radiology departments, laboratories, physical therapy departments and other health care providers. Pennsylvania law requires that all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law.

Your personal health information may be disclosed without your authorization in the following:

- **Required by Law** – We may disclose your PHI, but will limit the use of disclosure as required by federal, state or local law.
- **Public Health** – We may disclose your PHI to public health officials for purposes related to preventing or controlling disease, reporting injury, disability or death; reports to the Food & Drug Administration for adversities with medications or products; reporting child neglect/abuse and domestic violence.

- **Legal Proceedings**- We may disclose your PHI in the course of administrative or judicial proceedings and in response to a subpoena, discovery request or other lawful process. We will do so with written permission from you.
- **Public Safety –** We may disclose your PHI to law enforcement, Deans, counselors and campus security to protect you from harm to self or others.
- **National Security –** We may disclose your PHI for purposes of national security. PHI of US or foreign military members may also be disclosed to their respective authorities.
- **Health Oversight Activities –** We may disclose your PHI to health oversight agencies as required by law. Your information may be used for audits, investigations, inspections, licensures and other proceedings for the purposes of monitoring the health care system, government benefit programs and our compliance with your civil rights.
- **Workers' Compensation –** We may disclose your PHI to comply with workers' compensation laws.
- **Coroners, Funeral Directors and Organ Donation –** We may disclose your PHI to coroners, medical examiners, and funeral directors to aid in identification, determining cause of death and other duties performed as authorized by law. We may also disclose your PHI for organ donation purposes.

Other permitted and required uses and disclosures that may be made with your agreement or opportunity to object.

- **Others involved in your Healthcare and Emergencies –** We may disclose your PHI to a family member, close friend, or someone you request who is assisting in your care. We will use our professional judgment in releasing necessary information that we determine is in your best interest in the event you are unable to give consent. We may also disclose your information to emergency personnel in the event of an emergency. We will obtain your consent as soon as possible in this situation.

Your personal health information will only be used or disclosed with written authorization.

- **Psychiatric –** We require your written permission to share psychiatric PHI.
- **Other –** We may need your written permission for the use or disclosure of your PHI for reasons other than the previously mentioned.

Patient Rights and Responsibilities

You have the right to:

- Receive respectful and considerate care.
- Know the names and positions of your caretakers.
- Receive an explanation of your diagnosis, treatment and prognosis in layman's terms.
- Refuse treatment, except as prohibited by law, and to be informed of the consequences of such refusal.
- Request and receive an explanation of any charges incurred while in the SHC.
- Obtain a paper copy of the notice of information practices upon request.
- Request a restriction on certain uses and disclosures of your PHI: we are not required to agree with your request. If we do not agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
- Inspect and obtain a copy of your health records.
- Request an amendment to your health records.
- Obtain an accounting of disclosures of your health information.
- Request communication of your health information in a certain way or at a certain location. For example, you can ask that we use an alternative address for billing purposes.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Privacy Rights of Minors:

Situations that do not require a parent or other person to control the minor's health care decisions, and thus, does not control the PHI related to that care:

- PA law permits a minor to consent to all medical, dental and other health services, except abortion, if the minor has: (1) graduated from high school, (2) been married , and (3) been pregnant.
- Pa law permits a minor to consent to family planning and mental health treatment.
- When the minor obtains care at the direction of a court or a person appointed by the court.
- When the parent agrees that the minor and the health care provider have a confidential relationship.

To exercise any of your rights, please submit your request in writing.

Your Responsibilities are:

- To provide accurate personal and health history information necessary to complete your medical records.
- To ask questions pertaining to your understanding of your care, treatment or charges billed to you or your health insurance.
- To know and understand your health insurance plan.

Our duties are:

- Maintain the privacy of your health information**.**
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect about you through this notice.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you have to communicate health information by alternative means or at alternative locations.

Filing Complaints

If there is a concern about the process by which Eastern University's SHC allowed access to your health records or has violated your right to privacy you may contact:

Director of the Student Health Center
Eastern University
1300 Eagle Road
St. Davids, PA 19087

U.S. Department of Human Services
200 Independence Avenue
Room 509F, HHH Building
Washington, D.C. 20201