BROOKS HEALTH CENTER

Welcome to SC State University and Bulldog Country!

Student Health is our specialty, assisting students to maintain and improve their health in order to pursue their education and reach their goal of graduation.

We provide routine health services by medical professionals to meet the student's health needs and look forward to serving you at Brooks Health Center.

Attached you will find our health forms and information necessary to help us assist you with your health needs as you matriculate through SC State University.

Please complete forms online (instructions enclosed) and return pages 3-4 to the Health Center, retaining copy of pages 7-9 for your records.

If you need assistance, please contact the BHC staff at 803-536-7053.

Yours in health,

Pinkey Carter

Pinkey Carter, MHA BSN RN
Director

ONLINE STUDENT HEALTH INSTRUCTIONS

****NOTE: FIRST TIME FRESHMENS WILL NOT BE ABLE TO ACCESS ONLINE STUDENT HEALTH. YOU MAY STILL FAX OR E-MAIL YOUR INFORMATION. FAX NUMBER IS 803-533-3747/E-MAIL brookshealthcenter@scsu.edu.

1. GO TO South Carolina STATE UNIVERSITY WEB-SITE (SCSU.EDU).
2. CLICK ON THE BULLDOG CONNECTION TAB.
3. ENTER YOUR USERNAME AND PASSWORD FOR BULLDOG CONNECTION **IF YOU DON'T HAVE A USERNAME AND PASSWORD, YOU MAY GET ONE BY FOLLOWING THE INSTRUCTIONS UNDER HAVING PROBLEMS LOGING ON.
4. CLICK ON THE STUDENT RESOURCES TAB.
5. GO TO THE HEALTH SERVICES SECTION.
6. CLICK ON ONLINE STUDENT HEALTH.
7. ENTER YOUR USERNAME AND PASSWORD AGAIN.
8. CLICK ON MEDICAL FORMS TO DO YOUR MEDICAL HISTORY AND HIT SUBMIT WHEN FINISH.
9. CLICK ON IMMUNIZATIONS AND NEW TO ENTER YOUR IMMUNIZATIONS AND HIT SUBMIT WHEN FINISH.
10. CLICK LOG OUT.

TO FAX OR E-MAIL HEALTH INFORMATION GO TO HEALTH SERVICES ON SCSU WEB SITE AND INPUT YOUR INFORMATION. YOU MAY FAX THE FORMS TO 803-533-3747 or email to brookshealthcenter@scsu.edu

COMPLETE AND RETURN TO
Brooks Health Center
300 College Street NE
Post Office Box 7178
Orangeburg, South Carolina 29117
Phone: 803-536-7053 Fax: 803-533-3747

Health History and Physical Examination
SC State University

Semester of Enrollment (X): **___Fall ___ Spring ___ Summer Year 20____**

PLEASE RETURN BY: **JULY 14 (FALL)**
DECEMBER 1 (SPRING)

Please indicate enrollment status
☐ Freshman ☐ Transfer
☐ Graduate ☐ Distance Learning
☐ Returning *Check all that applies

"Good Health Comes First"

Print Name: Last _____ First _____ Middle _____

Date of Birth: _____ Student Identification #: **900**_____ Sex: F / M

Email address: **(university)** _____ **Cell Phone**: _____

Permanent Address: _____ Phone: _____
(Street, PO Box City State/Zip)

Parent/Guardian: _____ Home Telephone: _____

Work Telephone _____Cell/Mobile: _____

Emergency Contact Person: Name: _____ Phone: _____

Health/Hospital Insurance Policy Holder_____ Policy No._____

Insurance Company Address/Telephone: _____

The following health history is ***CONFIDENTIAL***, does not affect your admission status and, except in an emergency situation or by court order, will not be released without your written permission.

Family & Personal Health History (To be completed by Student/Parents)

√ =Normal or X= Abnormal (Explain)	Student	Family	Comments/Explanations
Cardiovascular/Heart	☐	☐	
Hypertension	☐	☐	
Stroke	☐	☐	
Diabetes	☐	☐	
Arthritis	☐	☐	
Lung (+) TB Test/Chest X-ray/Chronic Bronchitis **Asthma**	☐	☐	
Kidney/Recurrent Urinary Problems	☐	☐	
Gastrointestinal	☐	☐	
Liver	☐	☐	
Neurological	☐	☐	
Emotional or Mental Illness/ Retardation	☐	☐	
Surgery/Hospital/Emergency Room	☐	☐	
OB/GYN: Date of last Menstrual Period	☐	☐	
Vision Loss/Eye Disease	☐	☐	
Migraines/Vascular Headaches	☐	☐	
Sinusitis	☐	☐	
Anemia/SSD/SC/Thal/Traits	☐	☐	
Cancer/Immunodeficiency Disorder	☐	☐	
Rheumatic Fever	☐	☐	
Seizures/Convulsions	☐	☐	
Accidents/Injuries	☐	☐	
Drug/Alcohol/Tobacco Use/Abuse	☐	☐	
Allergies: Food, Medications, Dust, etc.	☐	☐	
STD's/GC, Chlamydia, NGU, other	☐	☐	
Dental Caries, Gum Disease	☐	☐	
Eating Disorder	☐	☐	
Other/Explain	☐	☐	

OVER >>>>>>

NAME: _____Date of Birth: _____ Student ID#:_____

Please list any drugs, medicines, birth control pills, vitamins, minerals, and any herbal/natural products (prescription and nonprescription) you use and how often you use them.

Name _____	Use_____	Dosage_____
Name _____	Use_____	Dosage_____
Name _____	Use_____	Dosage_____
Name _____	Use_____	Dosage_____

IMPORTANT INFORMATION.....PLEASE READ AND COMPLETE

STATEMENT BY STUDENT (OR PARENT/GUARDIAN, IF STUDENT UNDER AGE 18)

- I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless otherwise permitted by law. If I should be ill/injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the SC State University representative to release information from my (son/daughter's) medical record to a physician, hospital, or other medical professional involved in providing me (him/her) with emergency treatment and/or medical care.

- I hereby authorize any medical treatment for myself (my son/daughter) that may be advised or recommended by the physicians/nurse practitioner/nurses at Brooks Health Center.

- I am aware that the Brooks Health Center charges for some services, which are payable through the University's Cashier's/ Bursar's Office. I accept personal responsibility for payment of incurred charges. I am responsible for filing outpatient charges with my insurance and acknowledge that my responsibility to the university is unaffected by the existence of insurance coverage.

_____

Signature of Student **Date**

_____

Signature of Parent/Guardian, if student under age 18 **Date**

Brooks Health Center Staff Only: Received by: _____ Date: _____

NAME: _____Date of Birth: _____ Student ID#: 900____ _____

IMMUNIZATION REQUIREMENT

Student must complete mandatory Immunization requirements before returning this form to Brooks Health Center.

Required documentation of immunizations based on South Carolina Immunization Laws and South Carolina State University admission policy. (You may attach copy of all immunizations received.)

Acceptable Records of your Immunizations May be Obtained from any of the Following:

- Local Health Department
- Military Records or WHO (World Health Organization Documents)
- High School Records- These may contain some, but not all of your immunization information. Contact Student Health for help if needed. ***Your immunization records do not transfer automatically. You must request a copy.***
- Personal Shot Records-Must be verified by a doctor's stamp or signature, or by a clinic or health department stamp.
- Previous College or University- ***Your immunization records do not transfer automatically. You must request a copy.***

TO BE COMPLETED AND SIGNED BY HEALTHCARE PROVIDER:

1. REQUIRED IMMUNIZATIONS:

Proof of immunization or immunity is required of all students. **Form must be signed by your Health Care Provider or Health Dept.,** or a copy of an official certificate (such as from the military or Health Dept.) must be enclosed. All pages must have your name, date of birth and ID number on them. **Do not send until all items are complete including, if indicated, TB test with result recorded and signed, and chest x-ray report. Incomplete forms will be returned to you.**

1a. MMR (Measles (Rubeola), Mumps, Rubella): 2 doses (or the equivalent) required. Doses given before first birthday are not valid. Persons born before 1957 are exempt from this requirement. Proof of immunity may also be provided by blood test.

- **MMR** #1 Dose given after 1967 and after 1st birthday Date: _____/_____/_____
- **MMR** #2 Dose given at least 28 days after Dose #1 Date: _____/_____/_____

OR

- Immune Titers: Attach Lab Reports Date: _____/_____/_____

1b. MENINGITIS: A rare but serious, sometimes fatal bacterial infection that may be prevented by vaccination. ***Proof of immunization with meningococcal vaccine or a signed waiver declining the vaccine is required of all entering students. Parent signature required for students under 18.*** (http://www.cdc.gov/vaccines/vpd-vac/mening/who-vaccinate.htm)

- **MCV4 (Menactra/Menveo)/ MPSV4 (Menomune) (1)**Date: _____/_____/_____
  (2) Date: _____/_____/_____

OR After reviewing the information provided about the dangers of meningococcal disease, I decline the vaccine **(see attached)**.

Student Signature _____ Date:_____/_____/_____

Parent Signature _____ Date:_____/_____/_____

See our web page for more information at www.scsu.edu/studentaffairs/healthservice

2. RECOMMENDED but NOT MANDATORY:

- **TETANUS-DIPHTHERIA:** Booster within the last 10 years required.
  T dap – Date: _____/_____/_____ **OR Td-** Date: _____/_____/_____

- **HEPATITIS B**: A serious viral liver infection, preventable by vaccine.
  3 doses #1_____/_____/_____ **#2**_____/_____/_____ **#3**_____/_____/_____
  2 doses #1_____/_____/_____ **#2**_____/_____/_____ **or Titer Date** _____/_____/____ **Results** _____

- **HPV (Gardasil) #1** _____/_____/_____ **#2** _____/_____/_____ **# 3** _____/ _____/_____

- **Varicella (chicken pox)** series of two doses Date #1_____/_____/_____ #2 _____/_____/_____ **or**

  Date of Disease _____/_____/_____**Titer Date & immunity by positive blood titer (attach results)**

- **Tuberculin (TB) SKIN Test (Mantoux Only) 0.1ml ID** L or R forearm Date placed:_____/_____/_____
  TB Test result: _____**mm**. induration **Negative / Positive: Date read:** _____/_____/_____

Signature of health care professional reading test _____

If TB test is positive, **CHEST X-RAY** must be obtained. **Send written report.** Date of X-ray: _____/_____/_____ and Plan of Care**.(Attach disposition)**

_____ _____

Physician/Nurse Practitioner/Physician Assistant Signature **Address**

_____ **Telephone Number** _____ _____

City/State/Zip Code **Phone Number** **Date**

NOTE: This form will be retained by Brooks Health Center for 10 years, and then destroyed. Please make a copy of this form before mailing original.
RETURN THIS FORM TO: SC State University-Brooks Health Center; PO Box 7178; Orangeburg, SC 29117; (T) 803-536-7053; (F) 803-533-3747

Brooks Health Center Staff Only: Received by: _____ Date: _____

Revised: 5/09, 12/10, 4/12, 12/12, 4/14, 5/16

NAME: _____Date of Birth: _____ Student ID#: _____ _____

To be completed by Health Care Provider

Measurement and current health screening: (Give details and result when appropriate). (* Required Tests)

***Ht_____ *Wt _____ *B/P _____/_____ * (TPR) T _____ P_____R _____**

***HCT/HGB _____ *U/A Protein _____ Sugar _____ Blood _____**

Vision Screening: Left Eye with Glasses/Contact 20/ _____ Left Eye Without Glasses/Contact 20/_____

Right Eye with Glasses/Contact 20/_____ Right Eye without Glasses/Contact 20/_____

Clinical Evaluation (√= Normal or X = Abnormal, comments on all abnormal findings).

	Normal	Abnormal	Comments/Explanations
HEENT			
Skin			
Heart			
Lung			
Breast (Instructions on BSE: Yes or No)			
Abdomen/Hernia			
Musculoskeletal			
Vascular System			
Metabolic/Endocrine			
Neuropsychiatric			
Psychiatric			
Genitalia (include Last PAP Smear Result)			
Anus/Rectal			

Comment on overall physical and emotional health status: _____

Can student participate in **ROTC/SPORTS/PHYSICAL EDUCATION** (if desire)? YES ___ or NO ___ please comment below: _____

Please provide plan of care and describe support/resource needed for **any special problem or limitation(s) : _____**

_____

_____

****

_____ _____

Physician's/Nurse Practitioner/Physician Assistant Signature Address

_____ Telephone Number _____ _____

City/State/Zip Code Phone Number Date

Brooks Health Center Staff Only: Received by: _____ Date: _____

SOUTH CAROLINA STATE UNIVERSITY
BROOKS HEALTH CENTER
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW THIS CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

Your Health Record
We maintain your Medical History and Physical Form and Mandatory Immunization Record on file in B**rooks Health Center (BHC), electronically.** In addition, each time you seek care at **BHC**, a record of your visit is made. This record typically includes your symptoms, examinations, test results, diagnoses, treatments, plan for care, and any charges incurred (for medicine, lab tests, supplies, etc.).

Our Legal Duty
Federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires us to:

- Maintain the privacy of your medical information, Protected Health Information (PHI)
- Provide you with this notice about our privacy practices, our legal duties, and your rights concerning your health information.
- Abide by the practices described in this notice.
- Notify you if we change any of the policies described herein.
- This notice will remain in effect until we replace it.

As the law permits, we reserve the right to change our privacy practices and to make the new terms effective for all health information that we maintain, including information that we received or created before we made the changes. Written notices will be available in **BHC** and on the **Brooks Health Center website** @ www.scsu/edu/studentaffairs/healthservice.

Uses and Disclosures of Health Information
The following describes the different ways we may use or disclose health information. For each category of use or disclosure some examples are presented. Not every use or disclosure will be listed by example, but all of the ways in which we may use or disclose health information will fall into one of the following categories.
On Your Authorization: We may disclose health information about you with your written authorization, which you may revoke at any time in writing. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect. Without your written authorization, we may not use or disclose your health information for any reason except as described in this notice.
Treatment: The healthcare team at **BHC** uses your record/health information for assessing, planning, implementing, and evaluating your treatment. In addition, we may provide your health information to another physician or other healthcare provider providing treatment to you.
Healthcare Operations: We may use and disclose your information for our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
To Your Friends or Family Involved in Your Care: If a person such as a friend or family member is helping to care for you, we may release health information necessary for your care to them. Before we disclose any information to such people, we will provide you with an opportunity to object to that use or disclosure. In an emergency, if you are incapacitated or if you are not present, we may disclose health information based on our best professional judgment that use or disclosure of your information
is in your best interest. We may use professional judgment and common experience to allow another person to pick up your filled or written prescription, medical supplies or similar forms of health information, for example. We may disclose information to notify or assist in notifying a person involved in your care of your general condition and location.
Follow-up Reminders: We may phone you, leave a phone message at your personal voice mail or send you a card in the mail to remind you to phone or come to **BHC** for follow-up care or test results. We may phone you or send a card by mail to notify you of test results.
Disaster Relief: We may release information to public or private organizations authorized by law to handle disaster relief efforts
Business Associates: Another organization or Business Associate may perform some services provided by Brooks Health Center. For example, some of your laboratory tests are performed at Laboratory Corporation of America (Lab Corp.). Any Business Associate is required to safeguard your information.
Research: We may use or disclose information to researchers when SC State University has approved their research and protocols ensure the privacy of your health information.

Public Benefit: We may disclose health information for law enforcement purposes, in response to a subpoena, or as authorized by law for the following purposes considered to be in the public interest, safety, health or public benefit:

- to public health entities for disease and vital statistic reporting, child abuse reporting, adult or domestic abuse reporting, FDA oversight
- to employers to comply with Worker's Compensation law
- to health oversight agencies
- to law enforcement entities concerning crimes, victims, suspicious deaths
- to correctional institutions regarding inmates
- to the military and to federal officials for intelligence, counterintelligence, and national security
- to coroners, medical examiners, and funeral directors
- to avert a serious threat to health or safety

Your Health Information Rights

Although your health record is the physical property of the SC State-Brooks Health Center that compiled your record, the information belongs to you. Federal law gives you the right to:

- **Access:** You have the right to inspect and to obtain a copy of your records. Your request for records or copies **MUST** be in writing.
- **Restriction:** You have the right to request additional restriction on the use and disclosure of your health information. We do not have to agree to the restriction, but if we do, we will abide by the restriction. Any agreement regarding further restricting use of information must be in writing.
- **Alternative Communication:** You have the right to request that we communicate with you about protected health information by alternative means or at alternative locations. Requests **MUST** be in writing. We will accommodate reasonable requests.
- **Accounting of Disclosures:** You have the right to request a list of instances in which we or our business associates disclosed your health information which includes the purpose.
- **Amendment:** You have the right to request that we amend your health record if you think it is incorrect or incomplete. Your request **MUST** be in writing and **MUST** explain why we should amend your health information. We may deny your request. We will provide you with information about our denial and how to disagree with it.
- **Copy:** You have the right to receive a paper copy of this notice.

Questions and Complaints

If you have any questions about this Notice of Privacy Practice, or you believe that your privacy rights have been violated, you can file a complaint in writing with the SC State University-Brooks Health Center Privacy Officer or with the Secretary of the U.S. Department of Health and Human Services. We will provide you with the addresses to file your complaint upon request. We support your right to the privacy of your health information. There will be no penalty, threat, discrimination, or retaliation for a complaint to the Privacy Officer or the Department of Health and Human Services.

Acknowledgment of Receipt of Notice of Privacy Practices

I, (print name) _____, acknowledge that I received a copy of Notice of Privacy

Practices on _____ _____/_____/_____.

Signed_____

Meningitis on Campus
Know Your Risk

Meningococcal meningitis is a potentially life threatening bacterial infection. The disease causes inflammation of the membranes surrounding the brain and spinal cord. The disease is transmitted through the air via droplets of respiratory secretions and by direct contact with persons infected with the disease. Oral contact with shared items such as cigarettes or drinking glasses or through intimate contact such as kissing could put a person at risk for acquiring the infection. Meningococcal disease strikes 1,400 to 3,000 Americans each year and is responsible for approximately 150 to 300 deaths. Adolescents and young adults account for nearly 30 percent of all cases of meningitis in the United States. In addition, approximately 100 to 125 cases of meningococcal disease occur on college campuses each year, and five to 15 students will die as a result.

The Centers for Disease Control and Prevention recommends that college students be educated about the benefits of vaccination against meningitis (a potentially fatal bacterial infection). The recommendation is based on recent studies showing that college students, particularly freshman in residence halls, have a six-fold increased risk for meningitis. In June 2002, the State of SC passed the vaccination recommendation and education law: **TO REQUIRE PUBLIC INSTITUTIONS OF HIGHER LEARNING TO NOTIFY INCOMING STUDENTS, OR THEIR PARENTS, OF THE RISK OF CONTRACTING MENINGOCOCCAL DISEASE IF LIVING IN ON CAMPUS STUDENT HOUSING TO RECOMMEND VACCINATION AGAINST THIS DISEASE IN THE INSTITUTION'S HEALTH AND MEDICAL INFORMATION PROVIDED TO STUDENTS AND PARENTS**. SC State University encourages all students, parents and guardians to learn more about these serious communicable diseases and to make an informed decision regarding protection.

Know how meningitis is spread
Know the symptoms (often mistaken for the flu)
Know when to seek medical help
Know about the vaccine that helps prevent meningitis

SC State University **now** requires all incoming students to be immunized against **meningococcal disease**. The meningococcal vaccine will protect against four common forms of Neisseria Meningitis, however no vaccine is guaranteed to provide 100% protection. Minimal side effects may include mild pain and redness at the injections, occasional individuals may have reactions such as headache fever and chills. Consult with your family physician/health care provider or contact your local health department. The meningococcal vaccination is available at Brooks Health Center for a nominal fee.

For more detailed information, visit the websites for Centers for Disease Control (http://www.cdc.gov/vaccines/vpd-vac/mening/who-vaccinate.htm) or the American College Health Association (www.acha.org), visit Brooks Health Center (www.scsu.edu/studentaffairs/health).

Mandatory Health Insurance

Students are required to "enroll/waive on-line" each semester you attend.

Complete online

*www.studentinsurance.com

Students are automatically enrolled for the Student Health Insurance Plan when they register for the semester.

***Students must input/submit proof of comparable/equal insurance coverage to have the cost credited to your account.**

With an approved waiver, the University will "credit" the insurance fee to your account!

STUDENT HEALTH INSURANCE

ENROLLMENT

- Visit www.studentinsurance.com **(AIG)**

- ❖ "Find your Institution" **[right side of page]**
  - ✓ Select State: **South Carolina**
  - ✓ Select Institution: **SC State University**

- Under Quick Link: Click **Hard Waiver Enrollment**

- Don't forget to print the Confirmation Page or copy/record your confirmation number.

- **24 hours** after enrolling you can go back into the system, Click **My Account**, click **Go to account**. You will be prompted to provide your e-mail address and password previously used on the enrollment form. Then you will be allowed to print cards, update information, view claims, print claim forms, etc.

WAIVE

- Visit www.studentinsurance.com **(AIG):**

- ❖ "Find your Institution" **[right side of page]**
  - ✓ Select State: **South Carolina**
  - ✓ Select Institution: **SC State University**

- Under Quick Link: Click **Waive**

- Complete the Online Waive Form
- Don't forget to print your Confirmation Page or copy/record your confirmation number.
- **Student will receive 2 or more emails** from Pearce and Pearce Insurance with approved/denied. (If denied, 2nd e-mail will provide an explanation & steps to be taken to get student approved.) **Please follow e-mail instructions to make adjustments to waive.**

No adjustments will be made after the Waive Deadline.

With an approved waiver, the University will "credit" the insurance fee to your account! 3/2014