Required Student Health Forms

All new students are required the Patient Registration Form and Immunization Record.

Return to:

Wittenberg University Health Center
Wittenberg University
P.O. Box 720
Springfield, OH 45501
FAX: (937) 327-7812

Questions?

Call (937) 327-7811 or e-mail studenthealth@wittenberg.edu (e-mail preferred).

Deadline: July 15

This *checklist* is meant to help you complete your health forms in a timely manner. Please mail all completed health forms back to us together at your earliest convenience. Please do not hesitate to call the Health Center at (937) 327-7811 or e-mail us at studenthealth@wittenberg.edu if you need assistance with any Wittenberg University Student Health Form. For your convenience, the forms may be downloaded from our Web site at http://www.wittenberg.edu/administration/health_wellness/forms.

Incomplete information or invalid dates will prevent you from registering for future semesters and a HOLD will be placed on your account.

Checklist

1. Complete the Patient Registration Form and Immunization Record and return by **July 15.**
2. If you are under the age of 18, your parent or guardian must sign the Consent to Treat a Minor form.
3. Copy both sides of your insurance card and attach it.
4. Please mail all health forms to address above.

**Forms will be shared with the CMHP staff in the Wittenberg Health Center and Athletic Trainers in the Wittenberg Athletic Department (Varsity Athletes only).

wittenberg
UNIVERSITY

Dear Wittenberg students, parents and families,

In 2016, Wittenberg University partnered with Mercy Health and their locally integrated care delivery system, Community Mercy Health Partners (CMHP), to enhance the health services offered on campus. Mercy Health is Ohio's largest health system, the fourth largest statewide employer and twice named one of the nation's top 10 health systems by Truven, formerly Thomason Reuters. Community Mercy Health Partners is a locally operated integrated health care organization providing a wide range of health care services to patients throughout the Springfield and Urbana area. CMHP began operating the college's on-site student health center as of February 1, 2016. The partnership combines traditional on-campus care with expanded access to award- winning hospitals, primary care and specialty care physician practices, outpatient centers, and a variety of outreach programs.

A certified nurse practitioner, Trecia L. Narcelles, CNP, serves as the Director of Student Health Services and is familiar with college level student care and provides day to day oversight for on-campus diagnoses, treatment, and prescription services for common illnesses and injuries as employees of Community Mercy Health Partners. The Health Center is a satellite office connected with Springfield North Family Medicine in Springfield.

When making appointments, it is important for students to take both **an insurance card and ID** so that the Health Center can submit claims to the student's covering insurance provider for services rendered at the student Health Center. Applicable co-pays will apply and be collected at the time of service.

As always, Wittenberg advises that all students attending college, whether or not they live in Ohio, to call their insurance agent to notify them that they will be/are attending college at Wittenberg University located in Springfield, Ohio. It is the responsibility of the student/family to certify that his or her private insurance will pay for expenses incurred in this service area. Students/families will also need to know what the notification steps are to follow in order to notify their insurance carrier if health care is necessary, and to ensure that coverage will be provided. Depending on the type of insurance a student may have, he or she may find out that insurance will not cover expenses outside of a certain service area. In this event, the student/family should discuss your insurance needs with your agent and implement appropriate medical coverage.

Under the Affordable Care Act, it is the responsibility of all individuals to carry health insurance. Wittenberg University expects all students to carry appropriate coverage as required by the US government. If students do not have appropriate coverage, the Health Center will issue a fee for the services provided. Resources for securing health insurance coverage can be found at the following web link: http://www.wittenberg.edu/administration/health_wellness/insurance.html.

Lastly, it is important to note that the counseling program at Wittenberg operates independently from the Health Center. The Director of Student Counseling, Amanda Addy, is an employee of Wittenberg University. She and the Counseling Center staff meet with students free of charge. Our Counseling Center is able to provide crisis intervention and brief counseling services. Students needing ongoing care will be provided with referral services to other mental health resources in the local community.

Sincerely,

Casey Gill
Dean of Students

Wittenberg University Health Center

We want you to feel welcome here at the Wittenberg Health Clinic, now being managed by Springfield Regional Medical Group, a subpart of Mercy Health and Community Mercy Health Partners.

Mercy Health, a Catholic health care system, has been in existence for more than 160 years to extend the healing ministry of Jesus, emphasizing health care to people who are poor and under severed.
Mercy Health's core values are: compassion, excellence, human dignity, justice, sacredness of life and service.

Our goal here in the Clinic is to serve your medical and psychological health care needs. We believe that a student's health in both of these areas is vital for a successful college career. We are here to see and treat you for any acute illness, chronic medical problems, medication refills, and preventative services such as female exams and STD testing. We do offer some injectable medications for acute illness and I can prescribe almost any medication you might need.

In all, we want to provide you with a good experience as adults trying to navigate the health care system independently for the first time. If there are services that you need that we cannot provide, we have some wonderful specialists in the community and resources on campus to refer you to. We are collaborating with the physical therapists and athletic trainers at the HPER Center also.

I am a Family Nurse Practitioner with 12 years of experience- 7 years of primary care and 5 years in Hematology/Oncology. The staff and I look forward to meeting you and serving you during your time at Wittenberg University.

You can call us for an appointment that works with your schedule, but we also take walk in patients as well. The Health Center's phone number is (937) 327-7811.

Sincerely,
Trecia Narcelles, M.S., CNP
Director of Student Health Services

Wittenberg University – Consent to Treatment of Minor

Consent to Treatment of Minor (to be completed only if student is under the age of 18)

Student who are minors cannot be treated for health related services without parental or guardian consent unless: 1) the minor student is authorized by law to consent for treatment; or 2) obtaining informed consent is impracticable and a serious threat to the minor student's life or health exists that must be dealt with immediately.

I, _____ [name of parent, custodian, or guardian],

residing at _____ [address],

certify that I am the _____ [state relationship, e.g., parent or guardian] of

_____ [name of minor],

residing at _____ [address],

who is now _____ years of age.

In the event that there is a need for routine or emergency medical care that is the result of an injury and/or illness, I authorize and give consent for Wittenberg Health Center operated by CMHP and the Sports Medicine Department to administer all inpatient/emergency/outpatient medical care, encompassing routine diagnostic procedures and medical treatment by an attending physician, nurse practitioner, nurse, assistant, consultant or designee, and any necessary mental health or substance abuse counseling,

to _____.
[name of minor]

as is necessary in their professional judgment, in accordance with state law, and to refer _____
[name of minor]

to duly licensed medical facilities and/or practitioners when indicated. For surgical procedures, or more extensive medical care, attempts will be made to contact me before such care is initiated.

I further understand that once my child reaches the age of majority, my consent for treatment is no longer required.

Parent/Guardian Signature: _____ Date: _____

Wittenberg University – Immunization Record

TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE (to be completed by all incoming students)

Please answer the following questions:

Have you ever had close contact with persons known or suspected to have active TB disease? ☐ Yes ☐ No

Were you born in one of the countries or territories listed below that have a high incidence of active TB disease? (If yes, please CIRCLE the country, below) ☐ Yes ☐ No

Afghanistan	Congo	Iran (Islamic Republic of)	Namibia	Solomon Islands
Algeria	Côte d'Ivoire	Iraq	Nauru	Somalia South Africa
Angola	Democratic People's Republic	Kazakhstan	Nepal	South Sudan
Anguilla	of Korea	Kenya	Nicaragua	Sri Lanka
Argentina	Democratic Republic of the	Kiribati	Niger	Sudan
Armenia	Congo	Kuwait	Nigeria	Suriname
Azerbaijan	Djibouti	Kyrgyzstan	Northern Mariana Islands	Swaziland
Bangladesh	Dominican Republic	Lao People's Democratic	Pakistan	Tajikistan
Belarus	Ecuador	Republic	Palau	Thailand
Belize	El Salvador	Latvia	Panama	Timor-Leste
Benin	Equatorial Guinea	Lesotho	Papua New Guinea	Togo
Bhutan	Eritrea	Liberia	Paraguay	Trinidad and Tobago
Bolivia (Plurinational State of)	Estonia	Libya	Peru	Tunisia
Bosnia and Herzegovina	Ethiopia	Lithuania	Philippines	Turkmenistan
Botswana	Fiji	Madagascar	Poland	Tuvalu
Brazil	French Polynesia	Malawi	Portugal	Uganda
Brunei Darussalam	Gabon	Malaysia	Qatar	Ukraine
Bulgaria	Gambia	Maldives	Republic of Korea	United Republic of Tanzania
Burkina Faso	Georgia	Mali	Republic of Moldova	Uruguay
Burundi	Ghana	Marshall Islands	Romania	Uzbekistan
Cabo Verde	Greenland	Mauritania	Russian Federation	Vanuatu
Cambodia	Guam	Mauritius	Rwanda	Venezuela (Bolivarian
Cameroon	Guatemala	Mexico	Saint Vincent and the	Republic of)
Central African Republic	Guinea	Micronesia (Federated States	Grenadines	Viet Nam
Chad	Guinea-Bissau	of)	Sao Tome and Principe	Yemen
China	Guyana	Mongolia	Senegal	Zambia
China, Hong Kong SAR	Haiti	Montenegro	Serbia	Zimbabwe
China, Macao SAR	Honduras	Morocco	Seychelles	
Colombia	India	Mozambique	Sierra Leone	
Comoros	Indonesia	Myanmar	Singapore	

Have you had frequent or prolonged visits to one or more of the countries or territories listed above with a high prevalence of TB disease? (If yes, CHECK the countries or territories, above) ☐ Yes ☐ No

Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? ☐ Yes ☐ No

Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease? ☐ Yes ☐ No

Have you ever been a member of any of the following groups that may have an increased incidence of latent *M. tuberculosis* infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol? ☐ Yes ☐ No

IF the answer is YES to any of the above questions, Mercy Health and Wittenberg University requires that you receive TB testing as soon as possible, but at least prior to the start of the subsequent semester and record that information below. (This can be done at your local health department for minimal cost).

TUBERCULIN (TB) SKIN TEST OR QUANTIFERON GOLD BLOOD TEST:

DATE:_____Negative_____Positive_____

***A Positive TB test requires a chest x-ray**

IF the answer to all of the above questions is NO, no further testing or action is required.

Wittenberg University – Immunization Record

Patient's Name: Date of Birth:

Last First Middle Month/Date/Year

Required of all students

The information you provide on the form is strictly for the use of the Health Center (operated by Mercy Health) and the Sport Medicine Department and will not be released to anyone without your knowledge and consent. All full-time students must complete this form.

Tips on getting copies of immunization records:

1. Check with your parents or family members for records of childhood immunizations.
2. Contact your family physician or pediatrician.
3. Contact the clinic or hospital where shots were given.
4. Check your passport of other travel health records for overseas trips.
5. Call your elementary, middle, or high school for copies of immunization records.

Required Immunizations:

A. MMR (Measles, Mumps, Rubella) Two live immunizations required on or after the first birthday, at least 30 days apart.

1. Dose 1: ___/___/___ mo. day yr. 2. Dose 2: ___/___/___ mo. day yr.

A positive serological test for immunity to any of the above diseases is acceptable instead of immunizations.
A history of the disease is not acceptable.
Positive MEASLES titer: _____ Positive MUMPS titer: _____ Positive Rubella titer: _____

B. Meningococcal Quadrivalent vaccine 1. Dose 1: ___/___/___ mo. day yr. 2. Dose 2: ___/___/___ mo. day yr.

Strongly Recommended Immunizations:

C. Tetanus-Diphtheria-Pertussis

1. Primary series D Tap or DTP 1. _____ 2. _____ 3. _____

2. TDAP Booster (not TD or DT) within the last 10 years: _____

D. Polio

1. Primary series (minimum three dates required):
☐ OPV (oral) ☐ IPV (injected): 1. _____ 2. _____ 3. _____

E. Hepatitis B immunization series

1. Dose 1: ___/___/___ mo. day yr. 2. Dose 2: ___/___/___ mo. day yr. 3. Dose 3: ___/___/___ mo. day yr.

F. History of Chickenpox or chickenpox vaccine

1. Varicella vaccine ___/___/___ mo. day yr or 2. Chickenpox illness ___/___ mo yr.

G. Hepatitis A immunization series

1. Dose 1: ___/___/___ Dose 2: ___/___/___

H. Human Papilloma Virus Vaccine

1. Dose 1: ___/___/___ mo day yr. 2. Dose 2: ___/___/___ mo. day yr. 3. Dose 3: ___/___/___ mo. Day yr.

MERCYHEALTH
Physicians

WITTENBERG PATIENT REGISTRATION FORM

Date: _____ Anticipated college graduation year: _____

First Name _____ MI_____ Last Name _____ Date of Birth _____

Address _____ City _____ State _____ ZIP_____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

SS# _____-_____-_____ Sex: **M F** Email Address: _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Race: ☐ American Indian and Alaska Native ☐ Bi-Racial ☐ Middle Eastern ☐ Hawaiian/Pacific Islander
☐ Black or African American ☐ White/Caucasian ☐ Other ☐ Unknown

Sports you plan to participate in at Wittenberg: _____

Preferred Language _____

Employed: **Yes or No** Employer:_____

Emergency Contact Information:

Primary Care Physician: _____Address: _____

_____ Phone: ( ) _____ Fax: ( ) _____

Father/Guardian: _____ Address: _____

Work Phone: ( ) _____ Home ( ) _____ Cell ( ) _____

Mother/Guardian: _____ Address: _____

Work Phone: ( ) _____ Home ( ) _____ Cell ( ) _____

Alternate Contact: _____ **Home/Cell Phone:** ( ) _____

Primary Insurance: _____Subscriber Name: _____ Relationship: _____

DOB: _____ Policy Number: _____ Insurance Address:_____

Secondary Insurance: _____Subscriber Name: _____ Relationship: _____

DOB: _____ Policy Number: _____ Insurance Address:_____

Please read and initial each line. If you have questions, please ask us at the front desk for assistance.

1. _____ **I have enclosed a copy of my Primary and/or Secondary Insurance card/s front and back.**

2. _____ **I understand that my co-payment is due at each visit (if no insurance, a $45 office fee will be charged) I will bring a picture ID at each visit.**

NOTICE: I attest that the above information is correct to the best of my knowledge. I authorize the release of any medical or other information necessary to process the claim. I also request payment of insurance benefits either to myself or to the party who accept assignment. I authorize payment of insurance benefits to the physician or supplier for all services rendered. I also understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered or fees associated with my care. I also agree that I am responsible for any collection fees should my account be turned over to a collection agency.

_____ _____
Signature of Person Responsible (Student signature if 18 or older) Date