Norwich University Health Services
63 Crescent Avenue
Northfield, VT 05663
Tel: 802-485-2552 Fax: 802-485-4577
nuinfirm@norwich.edu

Dear Incoming Norwich Student,

Congratulations and welcome to the Norwich University community. We look forward to meeting you in the fall.
All incoming students must complete and return the "New Student Health Record" by June 1st

This information is returned directly to the Norwich University Health Services and will be filed in your student health chart. Your health information is confidential and will be reviewed only by the Norwich University Health Services staff. It cannot be shared or released without your written permission.

USE NORWICH FORMS ONLY, NO attachments; Independent forms will not be accepted and will be returned. Please keep a copy of your completed health forms for your records

Information required of all students

- Norwich Health History Form A1 and A2
- Norwich Physical exam (**conducted with in the last 6 months, prior to June 1 deadline**) **and** Immunization record signed by your health care provider Form B
- HIPPA Form and Varicella Documentation Form
- Complete health insurance information **AND** copies of both sides of your insurance card Form C

Mandatory Immunization Requirements Prior to Enrollment:

Vermont State law requires all incoming students born after 1956 to have proof of the following Immunizations prior to enrolling in College: 2 doses of MMR, Tdap, Hepatitis B Series, Varicella, and a Meningococcal Vaccine (1st year dorm students only). You may not register without proof of these immunizations.
Norwich University Health Services also requires a TB test (PPD) of all incoming students **in the last 12 months**. This is required of **ALL** incoming students.
Nursing Majors are required to have positive titers (blood tests) for Hep B and Varicella

Thank-you for completing your health forms carefully and completely. All forms of your "New Student Health Record" should be returned together by June 1st. **These forms must be sent directly to us.**

Sincerely,

Sarah L. Davies, MD

Medical Director

Complete this CHECKLIST before mailing your forms:

☐	Proof of required immunizations and vaccinations and Chickenpox waiver?	B & D
☐	Do you have proof of your PPD test in the last year?	B
☐	Completed Insurance Information?	C
☐	Copy of your insurance card (front and back) is **attached**?	C
☐	Physical Exam (in the last 6 mos) signed by your health care provider?	B
☐	Health History completed and signed by you?	A
☐	Did you keep a copy of the forms for your records?	
☐	**RETURN only NORWICH HEALTH FORMS TO HEALTH SERVICES,** please.	

A1.

Please circle all that apply:
CORP
CIVILIAN
COMMUTER
NURSING

Norwich University Health Services
Student Health History - Return by June 1st

Student's Full Name: _____________________________________ Date of Birth: ____________ Male___ Female___

Past Medical History

⇒ Do you have a history of any of the following health conditions? (circle all that apply)

ADHD or other learning disability
Alcohol use
Anemia
Asthma
Cancer
Clotting Disorders (hemophilia)
Concussion/Head Injury
Depression/Anxiety/other psychiatric disorder
Diabetes
Drug use or exposure to needles
Eating Disorders: Anorexia
Bulimia

Gastrointestinal condition
Gynecologic condition
Heart Murmur or heart condition
Hepatitis or jaundice
High Blood Pressure
HIV/AIDS or exposure to HIV/AIDS
Kidney Disease
Loss of paired organ (eye, kidney, testes, breast, etc.)
Migraine headaches
Orthopedic condition
Seizure Disorder (Epilepsy)
Thyroid Disease
Tobacco: Cigarettes / Dip Current Quit Date______
Tuberculosis

⇒ Please explain any positive responses to the above question: ____

____

____

⇒ Do you presently take any medications? YES NO
Please list any medication, supplements or birth control that you take on a regular basis. (Include the medication name & dose)

____

____

⇒ Do you have any allergies to medications? YES NO (If yes, list medication and reaction)

____

____

⇒ Do you have a history of orthopedic conditions (including fractures) that limited your participation in sports for longer than one month? YES NO (If yes, please explain)

____

____

⇒ Do you have any current conditions which restrict your participation in physical activity? YES NO
(If yes, please explain) ____

____

⇒ Do you plan to play a varsity sport? YES NO Sickle Cell Testing required of all Division 111 Athletes. Labs attached? Yes No

Student Signature: ____ **Date:** ________________

A2. **Norwich University Health Services**

Hospitalization and / or In-Patient Treatment Questionnaire

Printed Full Name: ________________________________Date of Birth________________

Have you ever been treated at a residential (overnight) facility or hospital for substance related issues?

Yes No

If yes, what? When: Time Period: Where:

Have you ever been treated at a residential (overnight) facility or hospital for mental health related issues?

Yes No

If yes, what? When: Time Period: Where:

Have you ever been treated at a residential (overnight) facility or hospital for an eating disorder or related issue?

Yes No

If yes, what? When: Time Period: Where:

Signature _____________________________________Date____________

B.

Norwich University Health Services
Physical Exam and Immunization Record – Return by June 1st

To be completed and signed by your health care provider (MD, DO, NP or PA)

Student's Full Name: ______________________________ Date of Birth: ____________

⇒ **Please review and update the student's medical history, medications and allergies on the previous page.**

Date of Physical Exam (**must be within the last 6 months of June 1st deadline**): PE Date____________

Height: _________ Weight: _________ Blood Pressure: _________ Pulse: _________

⇒ **Record your physical exam and describe any abnormalities:**

General appearance	Normal	Abnormal	Abdomen	Normal	Abnormal
HEENT	Normal	Abnormal	Genitals	Normal	Abnormal
Neck and thyroid	Normal	Abnormal	Skin	Normal	Abnormal
Heart	Normal	Abnormal	Neurological	Normal	Abnormal
Lungs	Normal	Abnormal	Psychological	Normal	Abnormal

Summary of abnormalities: ____

⇒ Is the student receiving medical care for a chronic condition or serious illness? YES NO

⇒ Do you feel that there are any mental or emotional issues that we should be aware of? YES NO

⇒ Do you have any concerns about the student participating in strenuous physical activity? YES NO

Summary of clinical concerns and recommendations: ______________________________

____

Immunizations

Required Immunizations Prior to Enrollment:

⇒ **Measles Mumps and Rubella** (MMR). Two doses **OR** evidence of positive titer is **required** for all students born after 1956.
Date of MMR #1: __________ Date of MMR #2: __________ OR Date of Positive Titer: _________

⇒ **Polio** (Strongly suggested)
Did student complete primary series of polio immunization? YES NO
Date of last booster: __________

⇒ **Tetanus-Diphtheria-Pertussis Booster (Tdap)** Date of Tdap Booster: ___________

⇒ **Hepatitis B Series** Must be started 6 months in advance of enrollment
Date of Hep B #1: _________ Date of Hep B #2: _________ Date of Hep B #3: _________ Date of positive titer______

⇒ **Varicella Disease*** (Chickenpox). History of Disease **OR** 2 doses **OR** evidence of positive titer.
Date of Disease:**_________ Dates of Immunizations: _______ and ________ OR Date of positive titer: _______

- ***All NURSING Majors MUST have positive titers for Heb B and Varicella. Please attach copy of lab results.***
- ***** A Vermont State Documentation of Varicella Form D MUST be signed.***

⇒ **Meningococcal Vaccine**. Date given: #1 ___________ #2____________ required if first vaccine given before age 16.

⇒ **PPD (TB test) in the last 12 months is required by Norwich University of all students.** ***Nursing Students need an annual PPD.***
Date given: ________ Date read: ________ Result: _________

⇒ **Sickledex (required of athletes) Date_______ , please attach report. Waiver available from NUAthletic Department**

Health Care Provider's Signature: ______________________________ **Date:** _______________

Health Care Provider's Name: ______________________________ **Telephone:** _____________

Address: ____ **Fax:** ________________

C. **Norwich University Health Services - Health Insurance Information**

Return by June 1st

___Female

___Male

Student's Full Name: ____ Date of Birth: ___________________

Home Address: ____ Social Security #: ________________

City:__________________________State____________________Zip____________ Home Telephone: ________________

Parent or Guardian Name: ____

Parent or Guardian Telephone (home & work): ____

Health Insurance Information

Name of Insurance: ____

Insurance's Street Address: ____

City: _______________________________________ State: ______________________ Zip: ___________________

Telephone #: _________________ Name of Subscriber: ___________________________Date of Birth: ____________

Employer of Subscriber: ____

Policy ID #: _________________________________ Group #: ____

⇒ **ATTACH readable photocopies of your Health Insurance, Prescription and Dental cards: front / back, to this form.**

⇒ **If you have Tricare, please apply for NORTH REGION to assure coverage.**

⇒ **Notify your Insurance Carrier of dependent status change; College Student (out of state where applies), to insure continued coverage. Please check for in network insurance coverage; all billable services are through Central Vermont Medical Center.**

⇒ Does your insurance company require referrals? YES* NO

⇒ Do you have full medical coverage (more than EMERGENCY services) in the state of Vermont? YES NO*

You will be required to take the health insurance program offered by Norwich University if you only have emergency medical coverage.

* I do not have APPROPRIATE health insurance and am aware that I must purchase the health insurance program offered by Norwich University. (See Office of the Bursar- Policy and Procedures) _____ Initial if applies

In addition to my regular health insurance, I plan to purchase the health insurance program offered by Norwich University. (See Office of the Bursar- Policy and Procedures) _____ Initial if applies

I hereby authorize direct payment to the Green Mountain Family Practice of benefits payable to me or on my behalf of the above-named patient, not to exceed the balance due for the professional services rendered. I understand that I am financially responsible and agree to pay Green Mountain Family Practice for charges not covered by this authorization. I also authorize the release of information requested by any insurance company, adjuster or attorney involved in the processing of a claim. A photocopy of this assignment shall be considered as effective and valid as the original. ***I understand that I am responsible for obtaining all referrals from my primary care provider should they be required.**

Student Signature: ____ Date: ___________________

Parent or Guardian Signature: ______________________________________ Date: ___________________

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General Information

Statement of Purpose:
Our mission is to provide complete high quality healthcare for the student population. This includes all primary care and most x-rays and orthopedic care. Overnight medical observation and treatment not requiring hospitalization are also available. Our goal is to return the sick or injured student to good health as quickly as possible. Our medical role includes the following: 1) advising on health issues campus wide 2) monitoring athletic programs and providing emergency services at events 3) individual medical and psychological care and appropriate referrals for specialty care.

Health Services Hours:
The Norwich University Health Services is a contracted service provided by Green Mountain Family Practice. It is staffed by three family physicians, a Physician's Assistant (PA), and a team of nurses.

From Monday to Friday medical care is available from 7:00 am until 11:00 pm. The MDs and PA see students on a walk-in basis at "sick call" from 8:00 am until 9:00 am and from 4:00 pm until 5:00 pm. At all other times during 7:00 am until 11:00 pm the student can consult with a nurse in our health center on a walk-in basis. Appointments are available with a Provider Monday through Friday from 9:00 am to 4:00 pm.

On weekends, the health center is staffed with a nurse on duty from 11:00 am until 7:00 pm. A physician or nurse practitioner is available to see students on Saturday and Sunday mornings for urgent health concerns. Students who require weekend care should call the Health Services at 485-2552 or go to the health center so their health concern can be addressed promptly.

There is 24 hour physician coverage via beeper for the student body during all school sessions. After hours the physician on-call can be paged by campus security or our answering service.

Available Health Services:
Many health services are available at no cost to students. These include: consultations with the physicians and nurses, overnight care in the health center, and many oral medications prescribed on a short term basis. There is a charge for x-rays, orthopedic supplies, labs, and surgical procedures. These are billed to a student's medical insurance. Direct billing to a student's medical insurance is a courtesy we extend to all of our patients. However, if we do not have full insurance information or the necessary referrals for care provided, a bill will be sent directly to a parent. The student and parent are responsible for obtaining any necessary referrals from their primary care provider. All students are required to have health insurance either through their family or with the insurance program offered through Norwich University (see Office of the Bursar information).

How To Reach Us:
Norwich University Health Services, commonly called the "Infirmary," is run by Green Mountain Family Practice. It is located on Crescent Avenue directly behind the gazebo across the street from Crawford Hall. On campus maps it is identified as Marsilius Hall.

We can be reached by telephone at 802-485-2552 between 7 am and 11:00 pm on weekdays and from 7:00 am until 7:00 pm on weekends. The Green Mountain Family Practice number is 802-485-4161. If you require immediate

care after hours, call Norwich campus security or our answering service. The answering service can be reached at 802-479-6060. We welcome students and parents to contact us directly with any questions or concerns.

Documentation of Varicella (Chickenpox) Disease

Vermont's School Immunization Regulations apply to students in attendance at any public or independent kindergarten, any elementary or secondary school and certain post-secondary schools. Before school entry, students must have the required immunizations, including 2 doses of varicella (chickenpox) vaccine. However, students who have had chickenpox disease can still enroll provided this form be completed, signed and provided to the school. Please note that this form does not need to be signed by a physician or other health care provider. **RETURN THIS FORM TO THE STUDENT'S SCHOOL.**

This document is being submitted on behalf of the following student:

Name:

______________________________________ ______________________

Last First

Date of Birth :

____/____/__________

I ____ verify that the above listed student

Parent/Guardian/Self (18 and over)

had varicella (chickenpox) disease in ______/__________.

Month Year

____ _____/_____/__________

Signature of parent or guardian of student or student 18 and over Date

RETURN THIS FORM TO THE STUDENT'S SCHOOL

The Vermont Department of Health
Immunization Program
108 Cherry Street
Burlington, Vermont 05401

802-863-7638 or
1-800-464-4343 ext. 7638
healthvermont.gov

Norwich University Health Services
63 Crescent Avenue
Northfield, Vermont 05663
802-485-2552 802-485-4161 802-485-4577 fax

Sarah L. Davies, MD Jamie Ramdles, MD Craig D. Sullivan, MD Deborah O'Hara, PA
Dawn Bailey, RN Alice Day, RN Jennifer Kelley, RN Anna Mary Zigmann, RN

I consent to allow Green Mountain Family Practice / Central Vermont Medical Center (CVMC) to use or disclose my protected health information for treatment, payment and health care operations.

> Treatment means the provision, coordination and management of health care related services by one or more health care providers.
> Payment means the activities undertaken by Green Mountain Family Practice or a health plan/health insurance carrier to obtain or provide reimbursement for the provision of health care.
> Health Care Operations include quality assessment and improvement activities, credentialing activities, education and training programs, arranging for medical review, legal services, auditing, business planning and management and administration.

I have the right to revoke this consent, in writing, at any time, except to the extent that Green Mountain Family Practice has taken action in reliance on this consent.

I acknowledge that I have received a copy of Green Mountain Family Practice's Notice of Privacy. (Patient Rights and Privacy Policy available on the Norwich website, under Health Care Checklist)

Name of Patient: ____
(Please Print)

____ Date: __________________
Signature of Patient or Patient Representative

____
Representative's Relationship to Patient