Norwich University Health Services
operated by Central Vermont Medical Center
158 Harmon Drive
Department Box 35
Northfield, VT 05663
Tel: 802-485-2552 Fax: 802-485-4577
nuinfirm@norwich.edu

___Female ___Male ___Transgender ___Full Time ___Part Time ___Commuter ___Flexible Pathways

Enrollment

Student's Full Name _____ Date of Birth _____

Norwich A# _____Social Security # _____ Student Phone _____

Home Address_____City_____State_____Zip_____

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 clear photocopies of your health insurance, prescription and dental insurance cards: front/back. *
If you have Tricare Insurance, please apply for the NORTH REGION plan to assure coverage. *
Notify your insurance carrier of dependent status change to "college student" to assure 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 applicable

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 applicable

***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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To be completed by primary care provider between 08/01/2020 and 06/01/2021 and submitted no later than 06/01/2021.

Student's Full Name: _____Date of Birth: _____

Allergies:_____

Date of Physical Exam: _____

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:_____

Current Medications (please also note if none are being taken) _____

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

Are there any current or past mental/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: _____

Required Immunizations Prior to Arrival*

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** Positive Titer lab report attached _____
Tetanus-Diphtheria-Pertussis Booster (Tdap) Date of Tdap Booster: _____(required within the last ten years)
Hepatitis B Series Date #1: _____ Date of Hep B #2: _____ Date of Hep B #3: _____ **OR**
Positive Titer lab report attached _____**Vaccine Series must be started 6 months in advance of enrollment**
Varicella Disease (Chickenpox). History of Disease **OR** 2 doses **OR** evidence of positive titer.
Date of Disease: _____ **OR** Dates of Immunizations: _____ and _____ **OR** Positive titer lab report attached_____
Meningococcal Vaccine. Date given: #1 _____ #2_____ (required if first vaccine given before age 16.)

PPD (TB) or Quantiferon testing done within the last 12 months is ONLY required for international students and high-risk US students. PPD testing is NOT available at NUHS and is a requirement prior to arrival on campus. Results need to be attached to this form upon submission.

Health Care Provider's Signature: _____Date: _____

Health Care Provider's Name: _____Phone: _____

Address: _____

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Authorizations to Release Patient Health Information

I _____, (Print name of patient and DOB) hereby authorize the use or disclosure of my individually identifiable health information to Norwich University Administration during the time I am enrolled at Norwich University. Any information released will be on a "need to know" basis only, and it will be used to provide appropriate support during and after any treatment. Examples of information to be shared include athlete treatment, concussion treatment plans, Restricted Duty forms, Accident Reports, overnight admission at NUHS, or emergency transport from NUHS to Central Vermont Medical Center.

_____ _____

Date Signature of patient

I also authorize the use or disclosure of my individually identifiable health information to the following entities as described below. I understand that if the person(s) authorized to receive the information are not part of a health plan (i.e. insurer,) employee or another healthcare provider, the released information may no longer be protected by the federal privacy regulations.

Person(s) to release information to:	Relationship to patient:
_____	_____
_____	_____
_____	_____

Purpose: _____

TO INCLUDE:
Psychotherapy/Mental Health Counseling Information/ Initials: ____ HIV Status/ Initials: ____

Section B: The patient must read the following statements:
I understand this authorization is voluntary. I understand that the person (or organization) I am giving permission to receive my information may re-release information, and that they may not be required by state or federal regulations to protect patient privacy. I understand my healthcare treatment and my healthcare bill will not be affected by this form. I understand that I may see the information I have described above, and I can receive a copy of the information upon my request. I understand I can revoke, or cancel, this authorization at any time by notifying Central Vermont Medical Center in writing. I also understand that revoking, or canceling, this authorization will not affect any release of information that had already occurred before I revoked this authorization. This authorization will expire upon my graduation or withdrawal from Norwich University.

_____ _____

Date Signature of patient

THE University of Vermont HEALTH NETWORK
Central Vermont Medical Center

Central Vermont Medical Group Practices

PATIENT AUTHORIZATION FORM

Date: _____ Patient Name: _____ Date of Birth: _____

INFORMED CONSENT FOR TREATMENT

I have chosen to seek evaluation and treatment with **Central Vermont Medical Group Practices.** My choice has been voluntary and I understand that I may terminate my treatment at any time, that in the interest of providing the best quality care my clinician will periodically seek consultation with professional colleagues, my clinician will record my visit in my clinical record with any information deemed clinically important, that my records will only be released in accordance with state and federal laws requiring confidentiality of such records, and that any release of information will be done only with a signed authorization by the patient or legal guardian.

PAYMENT AUTHORIZATION

I request that payments authorized medical benefits be made directly to **Central Vermont Medical Group Practices** for any services furnished to me by **Central Vermont Medical Group Practices**. I authorize any holder of medical information about me to release to insurance companies, their agents and the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I acknowledge that I am legally responsible for all charges associated with the provision on non-covered or non-medically necessary services. I understand that **Central Vermont Medical Group Practices** is not responsible for ensuring that I understand which services are covered or are not considered medically necessary by my insurance carrier/health plan, except where required by federal law. I understand it is my responsibility to review my insurance plan benefits and accept responsibility for payment should I choose to proceed with care. I agree to pay all charges for health care services not covered by my insurance carrier or any other payer of my medical benefits. In the event of non-payment, I understand non-payments will be reported to credit reporting agencies and agree to pay all reasonable costs of collection, including attorney's fees.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I agree to allow **Central Vermont Medical Group Practices** to release information regarding my medical treatment to any private or government insurance program that covers me, including Medicare and Medicaid, as necessary to verify benefits, authorize services, and process medical claims. In addition, release of medical records is authorized for my continuing care facility, any organization involved in the discharge planning process, any organization performing utilization review, and any health care agency as authorized by law.

NOTICE OF RECEIPT OF PRIVACY PRACTICES

The Notice of Privacy Practices describes the ways in which the **Central Vermont Medical Group Practices** use and disclose protected health information. By signing below, I acknowledge that the Notice of Privacy Practices has been made available to me for review and I have been offered a copy.

AUTHORIZATION TO LEAVE VOICE MESSAGES

I authorize **Central Vermont Medical Group Practices** to leave voice messages on my home, cell, or work telephone reminding me of scheduled medical appointments and other medical services for myself and/or my family members. I understand that no message will be left regarding confidential medical information.

_____ _____

Student Signature (if 18 years or older) **Date Signed**

_____

Parent/Guardian signature (if student is under 18 years old)

Academic Year 2021-22
Immunization Entry
Requirements

VERMONT
DEPARTMENT OF HEALTH

Vermont's Immunization Rule applies to all full-time undergraduate students, and any student enrolled in an allied health science program.

Upon matriculation an official immunization record must be presented to the student health center. Students can obtain these records from primary care provider's offices, previously attended schools, or State Immunization Registries. Failure to submit necessary documentation may delay registration for classes.

Students must provide documentation of the following vaccinations:

- 1 dose of Tdap (tetanus, diphtheria and pertussis) vaccine
- 2 doses of MMR (measles, mumps and rubella) vaccine
- 3 doses of hepatitis B vaccine
- 2 doses of chickenpox (varicella) vaccine. If the student has previously had chickenpox disease no vaccine or exemption is needed. Submit documentation of disease or sign the Health Department form
- 1 or 2 doses of quadrivalent meningococcal conjugate vaccine (MenACWY). This requirement is for first year students living in dormitories who are younger than age 22. Only those vaccinated before their 16th birthday need a second dose before college entry.

In the past 20 years, the overall incidence of meningococcal disease has decreased 10 - fold, due in part to the effectiveness of the meningococcal conjugate vaccine (MenACWY), recommended by the Centers for Disease Control and Prevention (CDC) since 2005. However, serogroup B is now the primary cause of meningococcal disease and outbreaks in young adults. Although a vaccine specific to serogroup B (MenB) is available, it isn't routinely recommended or required at this time. Students should review the need for MenB vaccine with their primary care provider.

An exemption for one or more immunizations based on medical or religious reasons is allowed under the rule. An exemption form must be completed and submitted in lieu of vaccination records to the student health center. This form is available at the Health Department's website: http://www.healthvermont.gov/immunizations-infectious-disease/immunization/k-12-school-nurses-and-administrators

Documentation of Varicella (Chickenpox) Disease

VERMONT
DEPARTMENT OF HEALTH

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

VERMONT
DEPARTMENT OF HEALTH

College Immunization Exemption

Vermont's Immunization Rule, adopted pursuant to 18 V.S.A. § 1123, applies to undergraduate students enrolled in colleges and universities. Before entry, students must have the required immunizations unless exempt for medical or religious reasons. In order to claim either exemption this form must be completed and returned to the student health center prior to school attendance.

Students who claim any exemption may be kept out of classes during the course of a disease outbreak if it is determined that such students are at risk for getting that disease and transmitting it to other students. The length of time a student is excluded from classes will vary depending on the disease, and can range from several days to more than a month.

Complete all information below on behalf of the student named. This form may not be altered.

_____ _____/_____/_____
Student first and last name Date of birth

MEDICAL EXEMPTION

Check only the specific vaccine(s) that is or may be detrimental to the patient's health:

☐ **Hepatitis B**	☐ **Tdap**	☐ **Varicella**	☐ **Meningococcal ACWY** 1st year dormitory residents only
☐ **Measles**	☐ **Mumps**	☐ **Rubella**	

Reason for medical exemption(s):_____

This exemption will likely continue until: _____/_____/_____.

The law requires that the student receive the vaccine(s) for which they are exempted when the vaccine(s) is no longer contraindicated.

_____ (____)_____
Print Name of Health Care Practitioner* **Telephone**

_____ ___/___/_____
Signature of Health Care Practitioner* **Date**

*According to Vermont statute, only a health care practitioner authorized to prescribe vaccines may sign the medical exemption form.

RELIGIOUS EXEMPTION

In signing this form I attest to holding religious beliefs opposed to immunizations. I acknowledge that I have reviewed evidence-based educational material provided by the Vermont Department of Health regarding immunizations including: information about the risks of adverse reactions to immunization; information that failure to complete the required vaccination schedule increases risk to the person and others of contracting or carrying a vaccine-preventable infection; and information that there are persons with special health needs who are unable to be vaccinated, or who are at heightened risk of contracting a vaccine preventable communicable disease, and for whom such a disease could be life-threatening. I request exemption from the vaccine(s) checked below:

☐ **Hepatitis B**	☐ **Tdap**	☐ **Varicella**	☐ **Meningococcal ACWY** 1st year dormitory residents only
☐ **Measles**	☐ **Mumps**	☐ **Rubella**	

_____ (_____)_____ ____/___/_____
Signature of Student (or parent if under 18 years) **Telephone** **Date**