

BARNARD Student Health Service

Please submit all forms via fax to 212.854.2702 (preferred method) or mail to:
Barnard College Student Health Service, Lower Level Brooks Hall, 3009 Broadway New York, NY 10027

The deadline to submit these forms is January 5, 2009

This form must be completed by your Doctor, not by your parent

Please Print Legibly

Student's Full Name (First, Middle, Last) _____ Last 4 digits of Social Security # _____

Date of Birth: _____

Date of Exam (must be within the last 6 months): _____

2 ITEMS REQUIRED BY NEW YORK STATE LAW FOR YOU TO REMAIN ON CAMPUS: (A and B)

A. Documentation of Measles, Mumps and Rubella Vaccination

Note to Physician: If patient has not received 2 measles, 2 mumps, and 1 rubella vaccination all after 1 year of age, please give her an MMR immunization during her visit. **No student will be permitted to register without complete immunization records.** This is a requirement under New York State Law, and we cannot allow any exceptions.

Measles vaccine _____ Mumps: _____ Rubella _____
(MM/DD/YYYY) (MM/DD/YYYY) (MM/DD/YYYY)

MMR #1 _____ MMR #2 _____
(MM/DD/YYYY) (MM/DD/YYYY)

Immune by Titer: Result _____ titer _____ Date: _____
(Negative or Positive) (MM/DD/YYYY)

B. Completion of Meningitis Response Form See page 3

REQUIRED BY BARNARD COLLEGE STUDENT HEALTH SERVICE:

Screening for Risk of Tuberculosis: Please answer Yes or No

Have you ever lived for at least 1 month in the Middle East, Africa, Asia, or Latin America? _____

Have you ever had close contact with anyone with tuberculosis? _____

Have you ever had close contact with anyone who is incarcerated, homeless, a migrant farm worker, HIV infected or an IV drug user? _____

If you answered Yes to any of the above questions, a PPD or Mantoux test is required.

Date of PPD placement: _____ Date of PPD Reading _____

Result of PPD: _____ negative _____ positive: _____ mm reaction

If positive:

Date of Chest X-ray: _____ Results of Chest X-ray: _____

TB prophylaxis given: _____

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Date of Birth: _____

Date of Exam (must be within the last 6 months): _____

Record of Immunizations:

Tetanus, Diphtheria, Pertussis: ___ Completed basic series Last booster date: _____ Tdap (date given): _____

Polio (IPV or OPV): ___ Completed basic series Last booster date: _____

Hepatitis B: Dose #1 (date) _____ Dose #2 (date) _____ Dose #3 (date) _____

Titer result _____ Date _____

Varicella (Chicken Pox): Dose #1 (date) _____ Dose #2 (date) _____

Titer result _____ Date _____

Gardasil (HPV) Vaccine: Dose #1 (date) _____ Dose #2 (date) _____ Dose #3 (date) _____

Allergies:

___ No known drug allergies

___ Allergic to the following medications: (please indicate reaction): _____

Please list all significant medical problems: _____

Please list all surgeries: _____

Please list all medications the student is currently taking: _____

Physical Examination: Height: _____ (in.) Weight: _____ (lbs) BP: _____ P: _____

Please list any significant abnormal medical findings:

Provider's Signature: _____

Date of exam: _____

Provider's Printed Name: _____

Office Address: _____

Provider telephone: _____ **Provider Fax:** _____

Please place Provider's Stamp in the box:

Submit via fax to 212.854.2702

Barnard Health Service Information and Consent Form

Welcome to Barnard Health Service! We are looking forward to working with you during your time at Barnard. Our clinical services offer a full range of primary care and women's health care with referral to outside consultants when indicated. **There is no charge for your visit. Most laboratory tests are without charge, as are x-rays, and other procedures we may order. A wide variety of medications are offered onsite at a significant discount.**

In addition to clinical care, we offer a variety of other services: nutrition counseling, stress reduction programs, sexual health counseling and peer health education and outreach through the Well-Woman program. We work closely with other health-related services, including the Furman Counseling Center, Alcohol Substance Awareness Program (ASAP), and the Barnard-Columbia Rape Crisis Anti-Violence Support Center. More information on staff, services, hours and links to other health sites is available at www.barnard.edu/health.

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), strict confidentiality is maintained for all health-related information and medical records within the Health Service. No information will be released outside the Health Service, either within the college or to your family, without your express prior consent. We operate as a clinic and therefore your clinician may consult with another clinician *within* the Health Service, ASAP or the Counseling Center if it is clinically necessary to provide you with the most appropriate care.

Our mission is not only to provide you with excellent and sensitive clinical care but also to enable you to become informed and knowledgeable health care consumers. We ask that you help us by providing feedback regarding your satisfaction with our services. Specifically, if you are dissatisfied with your care at any point, *please* either speak with the clinician involved, or with Brenda Slade N.P., M.A., Director of the Service (x4-2091 or bslade@barnard.edu).

PLEASE SEE THE BARNARD STUDENT HEALTH SERVICE NOTICE OF PRIVACY PRACTICES AS REQUIRED BY FEDERAL LAW, WHICH DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN HAVE ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

Receipt of Notice of Practice Information and Privacy Practices Written Acknowledgement

I have been made aware of and offered the opportunity to read a copy of Barnard College Student Health Service's Notice of Practice Information and Privacy Practices.

Signature of Patient

Date

Printed Patient Name

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Parent/Legal Guardian Section of Health Form

Consent for Treatment of Minors:

**If you are UNDER age 18 you MUST complete this form.
If you are OVER age 18 you do not have to complete this form. (Please print legibly)**

I, _____ hereby give permission to the clinicians at
(Name of Parent/Guardian)
Barnard College Health Services to provide medical care for _____.

I understand that clinicians are compelled by the laws of the State of New York to maintain my daughter's confidentiality with regard to all sexuality-related health needs.

Signature of Parent/Legal Guardian

Date

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