**Please complete and submit the following:**

- **Demographics and Consent to Treat Form** (page 2)
- **TB Questionnaire** (page 3)
- **Immunization Form** (page 4) (Or letter of religious/medical exemption): Please make sure that the form has been completed in its entirety prior to submission. A signed/stamped copy printed from your doctor's office or school will also be accepted.
- **Copy of the front and back of Insurance Card if available.**

***Fall Semester forms due July 1st and Spring Semester forms due December 1st***

**Please do not submit this page with your forms**

****Please read the following information carefully prior to submitting your forms****

- You may submit a letter of religious exemption in lieu of the provided immunization form. The letter must include the student's name printed and the student's signature. If the student is under 18, the letter must have the student's **and** a parent/guardian's signature.
- If you are medically exempt from receiving immunizations, we require signed documentation from your PCP.
- Student Health does **not** require a physical. We ask that you not submit a physical form, unless it includes immunization information.
- **Make sure everything is filled out in its entirety and signed prior to submitting.** Missing information/signatures will cause your forms to not be cleared.
- **Do not make multiple or partial submissions unless otherwise instructed.** It becomes confusing when a copy of the forms is emailed and then also arrives in the mail days later and can cause us to create multiple charts. If you receive an email that says you are missing something, please send the updated information as a reply so that we can keep all of the emails in one thread.

**Submitting your forms**

Please submit forms in only one of the following ways. **(Email or uploading to the portal is preferred)**

- Email them to HPUstudenthealth@novanthealth.org **please send forms as one combined PDF**
- Upload to the Student Portal
- Fax to 910-754-2009 or 336-841-4693
- Mail to 1300 N University Pkwy, High Point, NC 27268 **If mailing, please make a copy for yourself prior to sending**

Once we receive the forms, we print them, and a clinical staff member will review them. We will send an email if any required documentation is missing. Your portal will update to show if you have been cleared. This is a manual process that may take several days so we appreciate your patience.

**Additional Information:**

- For questions regarding the **Student Health Insurance** click here or contact Student Accounts at 336-841-9259 or studentaccounts@highpoint.edu.
- **Allergy Shots** information can be found at https://www.highpoint.edu/studenthealth/allergy-injection-administration/
- **ADD/ADHD refills** can be found at https://www.highpoint.edu/studenthealth/adhdadd-medication-refills/

**Demographics and Consent to Treat**

*Please print the Student's Information below as clearly as possible. Grad Students need not submit.*

| Name (Last/First/Middle) | | | Date of Birth (mm/dd/yyyy) | Phone number Student can be reached at |
|---|---|---|---|---|
| Mailing Address | | City | State | Zip Code |
| Sex | Race | Ethnicity | Student's Email Address | |
| HPU ID # | 1st Year at HPU? ☐ Yes ☐ No | Staring Semester (check) ☐ Fall ☐ Spring ☐ Summer | Incoming Class | |
| Emergency Contact Name | Emergency Contact Relationship | Emergency Contact Phone # | | |
| Primary Insurance | Member/Subscriber ID # | Group # | | |
| Policy Holder Name | Policy Holder DOB | Policy Holder Relationship | | |

**Authorization and Consent Form**

*Statement by student or parent/guardian (if student is under the age of 18):*

A. I have personally provided the above information (see checklist), 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 by court order or other legal requirements. However, if I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission for Student Health Services to release information from my (son/daughter's) medical records to any physician, hospital, or other medical agency involved in providing my (son/daughter's) emergency treatment and/or medical care.

B. I hereby authorize any medical treatment for myself (son/daughter) that may be advised or recommended by the medical providers of HPU Student Health Services.

C. I am aware that Student Health Services will file claims to student's health insurance for services received at the student health clinic and I accept personal responsibility for any co-pays, deductibles, or non-covered services billed by Novant Health that may apply. I am also aware that certain testing may be sent to outside facilities, including lab services, diagnostic imaging, or specialty care.

I understand that it is my responsibility to verify benefits coverage with my health insurance company.

I am aware that some charges for Student Health Services, such as medications filled within the clinic, may be billed through HPU Student accounts and I accept my personal responsibility for setting this account with HPU Student Accounts.

| **Signature of Student (**Required regardless of age**)** | **Date** | **Time** |
|---|---|---|
| **Signature of Parent/Guardian only if Student is under 18** | **Date** | **Time** |

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted _____ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)

## Tuberculosis (TB) Screening Questionnaire

**Please answer (check) yes or no to the following questions:**

- Have you ever had close contact with someone known or suspected to have active TB? ☐ **Yes** ☐ **No**
- Have you ever lived/worked/volunteered in a homeless shelter, prison/jail, or long-term care facility? ☐ **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? ☐ **Yes** ☐ **No**
  - Medically underserved ☐ **Yes** ☐ **No**
  - Low-income ☐ **Yes** ☐ **No**
  - Abusing alcohol or drugs ☐ **Yes** ☐ **No**
- Have you lived in, worked in, or visited a country other than the USA, Canada, or the UK for a period of longer than 6 months within the past 2 years? ☐ **Yes** ☐ **No**

****If you have answered yes to any of the above questions, you will need a PPD Tuberculin Skin Test or a QuantiFERON-TB Gold Test. Please include these results when submitting your forms.****

Name (Print): _____ DOB: _____

## Required Immunizations

**Name and DOB must be listed, or Student will not be cleared**

| **Name (Print Last/First/MI)** | | | **DOB(mm/dd/yyyy)** | |
|---|---|---|---|---|
| **Immunizations** | **Month/Day/Year** | **Month/Day/Year** | **Month/Day/Year** | **Month/Day/Year** |
| **DTap/Td** (3 doses)<br>*Typically given during infancy | | | | |
| **Tdap Booster**<br>*Must be within the last 10 years | | | | |
| **Polio** (4 doses)<br>*Not required if over 18 | | | | |
| **MMR** (2 doses)<br>*Given after 1st birthday | | | | |
| Or if separate: **Measles** (2 doses) | | | Titer date & Result: | Disease date: |
| **Mumps** (2 doses) | | | Titer date & Result: | Disease date not accepted |
| **Rubella** (2 doses) | | | Titer date & Result: | Disease date not accepted |
| **Hepatitis B** (3 doses)<br>* Not required if born prior to 7/1/94 | | | | |
| **Varicella** (1 dose)<br>*Not required if born prior to 4/1/01 | | | Titer date & Result: | Disease date: |

*Disease dates/Titer dates and results are accepted in place of vaccines when applicable.

**This form must have either a provider signature or an office ink stamp to be cleared.**

Provider Signature: _____ Date: _____ Time: _____

Provider Name (print): _____ Office Phone #: _____

Clinic name/address/ink stamp:

REQUIRED