



CASE

CASE WESTERN RESERVE UNIVERSITY

University Health Service

Case Western Reserve University
10900 Euclid Ave.
Cleveland, Ohio 44106-4901

WELCOME

Phone 216-368-2450
Fax 216-368-8530
E-mail healthservice@case.edu
<http://studentaffairs.case.edu/health/>

We're here to help with your health needs while you are in school. Even if you don't choose to take the Case Medical Plan (the insurance piece), you can use all of the staff at University Health Service and not have to pay for that! Visit us at:

<http://studentaffairs.case.edu/health>

We ask that you help us by completing two forms before you come to school:

1. The basic General Medical Information form, which asks for any allergies to drugs, any emergency medical information, and whether you wish to get 'allergy shots' while you are in school;
2. The Immunization Record—which asks you to send us a copy of your high school immunization form **OR** have your healthcare practitioner complete the form.

Why is the Immunization Record required?

1. For students entering the healthcare professions (nursing, medicine, dentistry, podiatry, social work), the immunizations **protect you** from acquiring vaccine-preventable infections from patients and **protect your patients** from acquiring these infections from you;
2. For students in other schools, these immunizations protect you from infections that you may be exposed to, especially with international travel.

Fill both of these forms out as best you can. If you need more information about immunizations or allergy shots, Connie Crihfield, Nurse Practitioner, can be reached at connie.crihfield@case.edu

These two forms should be completed and returned by:

July 1st (for fall semester) January 1st (for spring semester)

****if you receive the forms too late for these deadlines,
simply return them as soon as possible by regular mail.
(You do not need to express mail these to us).**

Eleanor W Davidson MD
Medical Director
eleanor.davidson@case.edu

Lois Wells CRNP
Director of Nursing
lois.wells@case.edu

Connie Crihfield MSN, CRNP
Director of Immunizations
connie.crihfield@case.edu

PRIVACY NOTICE UNIVERSITY HEALTH SERVICE

The staff of University Health Service has always been committed to a student's right to privacy. We value **highly** the information you choose to share with us; we respect your right not to share information when you feel you are not ready to do this.

We would like to let you know why we collect certain kinds of information from you and what how we use that information.

What We Collect

We ask you for your name, date of birth, social security number, and address so that we can:

1. identify you correctly within our medical records system
2. provide accurate information to identify you correctly when we send tests outside of the Health Service (for example, blood tests).

We ask you whom to notify in case of emergency so that we know how to contact someone close to you, in the unlikely event that you will not be able to do this yourself.

We ask for immunization information so that we may protect the entire university community from vaccine-preventable illness and, in the case of healthcare students, so that we may protect their patients from such illness.

What Information We May Disclose (and What We May Not Disclose)

We do not disclose any nonpublic personal information about students or former students to anyone, except as permitted by law. When we send specimens outside the Health Service for tests, we are required to provide the lab doing the test with identifying information. The information required varies with the test requested.

We cannot disclose your medical information to your parents, your professors, your deans, your future employer, or any other interested parties without a written Release of Information form, signed by you. (We don't give out your diagnosis, lab results, etc, to your parents or anyone else without your written permission.)

Questions/comments may be addressed to Dr. Eleanor Davidson, Director, UHS at (eleanor.davidson@case.edu).

CASE WESTERN RESERVE UNIVERSITY
UNIVERSITY HEALTH SERVICE*10900 EUCLID AVE*CLEVELAND, OH 44106-4901
(216)368-2450 ✓
General Medical Information

Name (print) _____ Maiden _____
Last First Middle Initial

Male ___ Female ___ S.S.# _____ - _____ - _____ Date of Birth: ____/____/____
US Social Security Number Month Day Year

Place of Birth: _____
City Country

Please check the school you will be entering? Case Undergraduate _____ Case Graduate _____

Case Weatherhead _____ Weatherhead School of Management _____ Law _____ Lerner Medical School _____

Nursing(MSN) _____ Nursing(BSN) _____ Nursing Doctorate _____ Medical School _____

Graduate School _____ Dental School _____ Dental Graduate Program _____ MSASS _____

Cleveland Institute of Art _____ Cleveland Institute of Music _____ Ohio College of Podiatric Medicine _____

When will you start classes? (Semester and Year) _____

If you have been previously enrolled at Case, indicate last school and dates attended:

School: _____ From: _____ To: _____

Home Address in Full: _____
Street

City State Zip Code Telephone (____)

Family Physician: _____
Name Street

City State Zip Code Telephone (____)

WHOM TO NOTIFY IN CASE OF EMERGENCY: _____

Relationship _____

ADDRESS: _____

Emergency contact options: Work (____) _____ Home(____) _____

Work (____) _____ Home(____) _____

E-mail address: _____ Cell Phone (____) _____

Please list any drug allergies that you have: _____

If you are now receiving allergy injections and plan to continue while in school, please indicate: YES ___ NO ___

NAME: (Please Print) _____

CASE WESTERN RESERVE UNIVERSITY
UNIVERSITY HEALTH SERVICE*10900 EUCLID AVE*CLEVELAND OH 44106-4901
(216) 368-2450

IMMUNIZATION RECORD

Please complete both sides of this form and return to the University Health Service.
PLEASE KEEP A COPY OF THIS FORM FOR YOUR OWN RECORDS

PART I: TO BE COMPLETED BY STUDENT

Name _____
Last First M.I.

Address: _____

_____ Date of Enrollment: _____

Date of Birth ____/____/____ Social Security # ____ - ____ - ____ Phone (____) _____
Month Day Year

PART II: TO BE COMPLETED BY A HEALTH CARE PROVIDER OR ATTACH A COPY OF YOUR HIGH SCHOOL IMMUNIZATION RECORD (Dates must include month, day and year.)
REQUIREMENTS ARE RECOMMENDED BY CENTER FOR DISEASE CONTROL AND AMERICAN COLLEGE HEALTH ASSOCIATION.

A. TETANUS-DIPHTHERIA

1. Completed primary series of tetanus-diphtheria immunizations. Date: ____/____/____
Mo Day Yr
2. Received tetanus-diphtheria booster within the last 10 years Date: ____/____/____
Mo Day Yr

TWO DOSES OF MEASLES ARE REQUIRED FOR ALL STUDENTS EXCEPT THOSE BORN BEFORE 1/1/1957

B. M.M.R. (Measles, Mumps, Rubella) If given instead of individual immunizations

1. Dose 1 - Immunized at 12 months or later, and before 5 years Date: ____/____/____
2. Dose 2 - Immunized at 5 years or after Date: ____/____/____

C. MEASLES (RUBEOLA) Check appropriate box

1. Born before 1-1-57 and therefore considered immune Date: ____/____/____
2. Has report of Measles titer. (Attach results) Date: ____/____/____
Specify results of titer: _____
3. Immunized with **LIVE** measles vaccine
Dose 1 - Immunized at 12 months or later, and before 5 years Date: ____/____/____
Dose 2 - Immunized at 5 years or later Date: ____/____/____

D. RUBELLA - Check appropriate box

1. Has report of Rubella titer (Attach results) Date: ____/____/____
Specify results of titer: _____
2. Immunized with vaccine at 12 months or later Date: ____/____/____

E. MUMPS - Check appropriate box

1. Has report of Mumps titer _____ (Attach results) Date: ____/____/____
2. Immunized with vaccine at 12 months or later Date: ____/____/____

NAME _____ SOC.SEC. # _____ - _____ - _____

F. **POLIO**

1. Completed primary series of polio immunization: Yes No
Type of vaccine: oral inactivated E-IPV (Date of Last Booster)Date:..... ____/____/____
Mo Day Yr

G. **TUBERCULOSIS** - Check appropriate box. (**REQUIRED FOR:** Students in the Schools of Dentistry, Nursing, Medicine, MSASS, Ohio College of Podiatric Medicine, the Masters in Anesthesia Program and the Lerner School of Medicine TB Skin Testing will be provided by the University Health Service after you are registered)

1. PPD (Mantoux) (Tine or monovac not acceptable) Specify date given and read .. ____/____/____ ____/____/____
Test Results: Negative Positive mm induration _____ Mo Day Yr Mo Day Yr

If positive, was a Chest x-ray done? Date _____ X-Ray Results: POS NEG

2. If PPD was positive, did you receive treatment with an anti-tuberculosis drug? Yes No

If Yes, specify drug and duration of treatment _____

3. Had BCG Vaccine(bacillus Calmette-Guérin) in the past - specify year. ____/____/____
Test Results: Negative Positive Mo Day Yr

H. **CHICKEN POX**

1. Had disease.Date . ____/____/____

2. Received Chicken Pox Vaccine:..... Dose #1: Date ____/____/____ Dose #2: Date ____/____/____

3. Varicella titer done - Results: _____ (Attach results) Date. ____/____/____
This is strongly recommended for students in Medicine, Dentistry, OCPM and the Masters in Anesthesia Program who have not had the disease. **It is REQUIRED for the students in the Doctor of Nursing Practice and BSN programs.**

I. **MENINGOCOCCAL VACCINE**.....Date: ____/____/____ (Optional for everyone)

J. **HEPATITIS A VACCINE**.....Dose #1: Date: ____/____/____ Dose #2: Date: ____/____/____ (Optional for everyone)

K. **HEPATITIS B VACCINE** - Name of Vaccine _____

1. Dose #1 Date ____/____/____

2. Dose #2 Date ____/____/____

3. Dose #3 Date ____/____/____

L. **Results of Hepatitis B Serology** (if any)

HBsAg Results: (Antigen) _____ (Attach results) Date: ... ____/____/____

HBsAb Results: (Antibody) _____ (Attach results) Date: ... ____/____/____

Students entering the schools of DENTISTRY, MEDICINE, NURSING, OCPM and the Masters in Anesthesia Program must supply all of the information requested on this form except where indicated as optional. Without this information you may be delayed in starting some clinical activities.

HEALTH CARE PROVIDER INFORMATION:

NAME: _____ ADDRESS: _____

SIGNATURE: _____ PHONE: (____) _____ DATE _____