Keiser University

Health and Medical Forms

The Health and Medical Form Packet must be completed and submitted by ALL new and residential.

Student Athletes:

Student Athletes must complete this form in addition to any health or physical forms that are required to be submitted for a sport.

Please note:
KU Health and Medical Forms must be submitted to the following departments:
New Students - The Office of Admissions Located in the Turner building.
Returning Residential Students - Dean of Students located in the Turner building.

Completed Forms must be sent to:

Keiser University
Attn: Turner Education Building 2nd Floor
2600 N. Military Trail
West Palm Beach, FL 33409

Keiser University

Health and Medical Form

STUDENT INFORMATION:

Student Last Name | First Name | Middle Initial | Today's Date

Social Security Number | Student ID | Date of Birth | Gender Identity

Are you living __ On Campus (Residential) __ Off Campus (Commuter)

Number & Street Address (Permanent Address)

City | State | Zip | Country

EMERGENCY NOTIFICATION: In case of emergency, please notify:

Contact Last Name | First | Relationship to Student

Number & Street Address

City | State | Zip | (___)______________ Home Phone | (___)______________ Cell Phone

PERMISSION TO TREAT:
Health center personnel associated with Keiser University have permission to proceed with any needed medical or minor treatment and diagnostic exams for:

Name of Student – Please Print | Student's Signature

REQUIRED AUTHORIZATION FOR CARE OF STUDENTS UNDER AGE 18:
In the event of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by the attending Physician to contact me in the most expeditious manner possible. If said Physician is unable to communicate with me, the treatment necessary for the best interest of the above-named student may be given.

Parent or Guardian Name | Signature | Relationship to Student

MEDICAL INSURANCE INFORMATION:

Do you have the Keiser University medical insurance coverage? **YES** ☐ **NO** ☐

MEDICAL INSURANCE WAIVER: To waive the Keiser University medical insurance, you must log into www.insuranceforstudents.com/ku complete the insurance waiver portion of this website

---

PERSONAL MEDICAL HISTORY:

Check the appropriate space for any illnesses that you have had or currently have.

___Alcoholism ___Anemia, sickle cell
___Anemia ___Asthma
___Bleeding tendency ___Bronchitis
___Depression ___Diabetes
___Ear infections
___Epilepsy or seizure disorder
___Heart murmur ___Hepatitis
___High Blood Pressure
___Hypoglycemia ___Kidney infection
___Kidney stones ___Malaria
___Meningitis ___Mononucleosis
___Thyroid disorder ___Tuberculosis
___Headaches, migraine_____Headaches (other)
___Heart murmur
___Other Heart problem
Please specify:________________

DISABILITY

Do you need special accommodations? **YES** ☐ **NO** ☐

If yes, please explain:

____
____

DRUG ALLERGIES

Please list any drugs that you are allergic to. An allergic reaction may cause hives, skin rash, swollen eyes, difficulty breathing, swollen joints or glands, and fever. Nausea, vomiting and diarrhea may also occur.

____
____
____

MEDICATIONS

Please list any current medications:

____
____

OTHER ALLERGIES

Please list any items that you are allergic to. (Allergies other than drugs).

____
____

OTHER HEALTH ISSUES

Do you drink alcoholic beverages? Yes_____No______
If yes, how often? Rarely______ Frequently_____ Every weekend_____ Every day_____
Have you ever smoked nicotine cigarettes? Yes_____No______
If yes, which did (do) you smoke regularly? Check all that apply: Cigarettes____ Cigars_ Pipe ___
Have you had a dental examination in the past year? Yes______No_____

REQUEST FOR RELEASE OF MEDICAL RECORDS:

(Name)______________________________I HEREBY REQUEST THAT MY MEDICAL RECORDS BE RELEASED TO: Keiser University

______________________________ ____________________

Patient's Signature **Date**

The above will be used only in the event of medical necessity.
Do not automatically send all your medical records to the University Health and Wellness Center

IMMUNIZATIONS

To comply with Florida Administrative Code 6C-6.001(5) all students must submit documented proof of immunity to Measles (Rubella) and German Measles (Rubella) – either by vaccination or proof of disease. On campus students have additional immunization requirements. Florida Statute 1006.69 mandates that dormitory residents submit documentation of vaccination against both Hepatitis B (a series of 3) and Meningococcal Meningitis or sign the corresponding waivers.

To comply with Florida Statute 1006.69, all students living on campus must submit documentation of vaccination against Hepatitis B and Meningococcal Meningitis or sign a waiver for each vaccine (see enclosed immunization record). Commuter students may still be at risk for meningococcal disease because this infection is easily transmitted through the air droplets of respiratory secretions – close contact with other students during classes and activities (such as kissing and/or sharing utensils, drinking glasses, water bottles or cigarettes) increases that risk.

Meningococcal disease is a rare, but potentially fatal bacterial infection that can cause meningitis – severe swelling of the brain and spinal cord or meningococcemia – a serious blood infection. Meningococcal disease often begins with symptoms that look like other common viral illnesses such as the flu. However, unlike a cold or flu, meningococcal disease can get work very rapidly, and can kill an otherwise healthy person in 48 hours or less. One out of 5 people who develop this disease will die. Of those who survive, 1 in 5 will suffer from permanent disabilities such as amputation, brain damage, hearing loss and seizures. The vaccine protects against four types of the bacteria that cause meningitis in the United States- types A, C, Y and W- 135. Up to 83% of the cases in adolescents and young adults are potentially vaccine preventable.

Hepatitis B is a serious liver disease that can lead to cirrhosis or liver cancer. In most cases, it infects people between the ages of 15 and 39. People can carry the virus for long periods of time and infect others through blood, secretions, or intimate sexual contact. The series of 3 Hepatitis B vaccines is available at the Palm Beach County Health Department.

Students residing on-campus **must** provide documentation of vaccination against both diseased in addition to their general childhood immunizations. You are responsible for submitting documents to the Health and Wellness Center indicating that you are immunized against these diseases. If you choose not to be vaccinated against either and/or both diseases, you must sign the corresponding waiver(s), which are included on the immunization record form enclosed.

IMMUNIZATION RECORD

Student's Name:__________________________Birth Date:__________ Student ID: __________________________

Students born on or after 1/01/57 must provide proof of **two** Measles (Rubeola) and **one** German Measles (Rubella) immunizations. A positive titer for Measles (Rubeola) and German Measles (Rubella) antibodies is acceptable proof of disease (immunity). Students born before 1/01/57 are considered naturally immune to Measles (Rubeola) and German Measles (Rubella).

Section A TO BE COMPLETED BY AUTHORIZED MEDICAL PERSONNEL

REQUIRED FOR ALL STUDENTS:

1st MMR ______/______/______ 2nd MMR______/______/_____

1st Measles ______/______/______ 2nd Measles______/______/_____

1st German Measles ______/______/______

REQUIRED FOR ON-CAMPUS STUDENTS:

On campus students are required to either have immunizations for Hepatitis B and Meningococcal meningitis OR complete the waiver(s) below in Section B.

Hepatitis B dose 1: ______/______/______ Meningitis_____/_____/______

dose 2: ______/______/______

dose 3: ______/______/______

RECOMMENDED FOR ALL STUDENTS:

Mumps ______/______/______TB skin test (PPD)_____/______/_____

Polio (most recent dose) ______/______/______mm____Pos______Neg______

Td (most recent dose) ______/______/______Chicken Pox (varicella)______/____/_____

______________________________________ ________________

Physician/Authorized Signature **Date**

OTHER:

COVID-19 dose 1: _____/______/______ dose2:_____/_____/_______

Section B TO BE COMPLETED BY ALL STUDENTS

I have received the required information regarding the risks of acquiring **Bacterial Meningitis** and **Hepatitis B** and the benefits of receiving immunization to reduce those risks. I also understand that if I live in campus housing during my enrollment at Keiser I am required to receive these immunizations or actively decline these immunizations.

___I have provided proof of these immunizations (see above).

___I decline receiving Menomune vaccine for bacterial meningitis and acknowledge receipt of information regarding this disease.

___I decline receiving Hepatitis B vaccines. I acknowledge receipt of information regarding this disease.

Section C TO BE COMPLETED BY ALL STUDENTS

I have read and understand these immunization requirements and have truthfully completed this form to the best of my knowledge.

Student Signature _________________________________ Date ________________

Hepatitis B Vaccine Waiver

I understand that under Florida State Law, students enrolled in a Florida institution of higher education and who reside in on-campus housing, are required to be vaccinated against Hepatitis B or may seek exemption from this law. I have read the informational letter from Keiser University Health and Wellness Center. I acknowledge the detrimental effects of this disease. Lastly, I have read and understand the availability and effectiveness of the vaccine which is available through the Palm Beach County Health Department.

I do not wish to be vaccinated against Hepatitis B and I voluntarily agree to release, discharge, indemnify and hold harmless the State of Florida, Keiser University, its officers, employees and agents from any and all costs, liabilities, expenses, claims, demands, or causes of action on account of any loss or personal injury that might result from my not being vaccinated against Hepatitis B.

Student Name:________________________________Student Signature:_____________________________Date:_________________

If the student is under age 18, a parent/guardian must also sign this waiver.

Parent/Guardian:_______________________________Signature of Parent/Guardian:____________________Date:_________________

____

Meningitis Vaccine Waiver

I understand that under Florida State Law, students enrolled in a Florida institution of higher education and who reside in on-campus housing, are required to be vaccinated against meningococcal disease or may seek exemption from this law. I have read the informational letter from Keiser University Health and Wellness Center. I acknowledge the detrimental effects of the disease.

I do not wish to be vaccinated against meningococcal disease and I voluntarily agree to release, discharge, indemnify and hold harmless the State of Florida, Keiser University, its officers, employees and agents from any and all costs, liabilities, expenses, claims, demands, or causes of action on account of any loss or personal injury that might result from my not being vaccinated against meningococcal disease.

Student Name:________________________________Student Signature:_____________________________Date:_________________

If the student is under age 18, a parent/guardian must also sign this waiver.

Parent/Guardian:_______________________________Signature of Parent/Guardian:____________________Date:_________________

____

Acknowledgement of Receipt of Notice of Privacy Practices **(Found on Page 7 and 8)**

The undersigned Patient or legally authorized representative ("Agent" is the legal guardian if student will not be 18 years of age prior to the start of the fall term) of the Patient acknowledges that he or she personally received a copy of the Keiser University Health and Wellness Center's Notice of Privacy Policies on the date indicated below.

Printed Name:_________________________________Date of Birth:___________Social Security Number:_________________________

Signature:_____________________________________Date:_________________

Information about Agent (if patient will not be 18 years of age prior to the start of the fall term)

Agent Name (parent or guardian):____Relationship to Patient:__________________________

Signature:_____________________________________Date:_________________

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INOFMRATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Overview

The law requires us to keep your protected health information ("PHI") private in accordance with this Notice of Privacy Practices ("Notice"), as long as this Notice remains in effect. We are also required to provide you with a paper copy of this Notice, which contains our privacy practices, legal duties, and your rights concerning your PHI.

From time to time, we may revise our privacy practices and the terms of our Notice at any time, as permitted or required by applicable law. Such revisions to our privacy practices and our Notice may be retroactive. Our Notice will be updated and made available to our patients prior to any significant revisions of our privacy practices and policies.

Organizations Covered by this Notice [Optional language from Organized Health Care Arrangements]

This Notice contains the privacy practices for [types of organizations] listed below, with the [types of facilities] sites they maintain for delivery of health care products and services. Each of these organizations participates in an organized health care arrangement and may use and disclose your PHI among themselves as they shall deem appropriate for your treatment, payment or health care operations.

Our privacy Practices

Use and Disclosure. We may use or disclose your PHI for treatment, payment, or health care operations. For your convenience, we have provided to you.

- *Treatment.* Your PHI may be used by or disclosed to any physicians or other health care providers involved with the medical services provided to you.
- *Payment.* Your PHI may be used or disclosed in order to collect payment for the medical services provided to you.
- *Health Care Operations.* Your PHI may be used or disclosed as a part of our internal health care operations. Such health care operations may include, among other things, quality of care audits of our staff and affiliates, conducting training programs, accreditations, certification, licensing, or credentialing activities.

Authorizations. We will not use or disclose your medical information for any reason except those described in this Notice, unless you provide us with a written authorization to do so. We may request such an authorization to use or disclose your PHI for any purpose, but you are not required to give us such authorization as a condition of your treatment. Any written authorizations from you may be revoked by you in writing at any time, but such revocation will not affect prior authorized used or disclosures.

Patient Access. We will provide you with access to your PHI, as described below in the Individual Rights section of this Notice. With your permission, or in some emergencies, we may disclose your PHI to your family members, friends, or other people to aid in your treatment or the collection of payment. A disclosure if your PHI may also be made if we determine it is reasonably necessary or in your best interest for such purposes as allowing a person acting on your behalf to receive filled prescriptions, medical supplies, X ray, ect.

Facility Directories. [Optional Language for Inpatient facilities] Our facilities directory may list the following information about you: (1) your name, (2) your location in our facility, (3) your general condition without reference to specific medical information, e.g., stable, serious, fair, ect., and (4) your religious affiliation, if any. Our facility directory information may be disclosed to clergymen and except for religious affiliations, to other people. You may restrict or prohibit the release of the above information.

Locating Responsible Parties. Your PHI may be disclosed in order to locate, identify, or notify a family member, your personal representative, or other person responsible for your care. If we determine in our reasonable professional judgment that you are cable of doing so, you will be given the opportunity to consent to or to prohibit or to restrict the extent or recipients of such a disclosure. If we determine that you are unable to provide such consent, we will limit the PHI disclosure to the minimum necessary.

Disasters. We may use or disclose your PHI to any public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Required by Law. We may use or disclose your medical information when we are required to do so by law. For example, your PHI may be released when required by privacy laws, workers' comprehension or similar laws, public health, court or administrative orders, subpoenas, certain discovery requests, or other laws, regulations or legal processes. Under certain circumstances, we make limited disclosures of PHI directly to law enforcement officials or correctional intuitions regarding and inmate, lawful, detainee, suspect, fugitive, material witness, missing person, or victim or suspected victim of abuse, neglect, domestic violence or other crimes. We may disclose your PHI to the extent reasonably necessary to avert a serious threat to your health or safety of others. We may disclose your PHI when necessary to assist law enforcement officials to capture a third party who had admitted to a crime against you or who has escaped from lawful custody.

Deceased Persons. After your death, we may disclose your PHI to a coroner, medical examiner, funeral director, organ procurement organization in limited circumstances.

Research. Your PHI may also be used or disclosed for research purposes only in those limited circumstances not requiring your written authorization, such as those which have been approved by an institutional review board that has established procedures from ensuring the privacy of your PHI.

Military and National Security. We may disclose to military authorities the medical information of Armed Forces personnel under certain circumstances. When required by law, we may disclose your PHI for intelligence, counterintelligence, and other national security activates.

Your Individual Rights

Access to Copies. In most cases, you have the right to review or to purchase copies of your PHI by requesting access or copies in writing to our Privacy Officer. Please contact our Privacy Officer regarding our copying fees.

Disclosure Accounting, You have the right to receive an accounting of the instances, if any, in which your PHI was disclosed for purposes other than those described in the following sections above: Use and Disclosures, Facility Directories, Patient Access, and Locating Responsible Parties. For each 12-month period, you have the right to receive one free copy of an accounting certain details surrounding such disclosures that occurred after April 13, 2003. If you request accounting more than once in a 12-month period, we will charge you a reasonable, cost-based fee for each additional request. Please contact our Privacy Officer regarding these fees.

Additional Restrictions. You have the right to request that we place additional restrictions on our use or disclosure of your PHI, but we are not required to honor such requests. We will be bounded by such restrictions only if we agree to do so in writing signed by our Privacy Officer.

Alternate Communications. You have the right to request that we communicate with you about your PHI by alternative means or in alternative locations. We will accommodate any reasonable request if it specifies in writing alternative means or locations and provides satisfactory explanations of how the future payments will be handled.

Amendments to PHI. You have the right to request that we amend your PHI. Any such request must be in writing and contain a detailed explanation for the requested amendment. Under certain circumstances, we may deny your request but will provide you a written explanation of the denial. You have the right to send us a statement of disagreement to which we may prepare a rebuttal, a copy of which will be provided to you at no cost. Please contact our Privacy Officer with any further questions about amending your medical records.

Complaints

If you believe we have violated your privacy rights, you may complain to us or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with us by notifying our Privacy Office. We support your rights to protect the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.