

NORWICH UNIVERSITY HEALTH SERVICES

802-485-2552 (P) / 802-485-4577 (F)

healthservices@norwich.edu

*****DUE NO LATER THAN JULY, 15th*****

Name: _____ Date of Birth: _____
First Middle Last Month/Day/Year

Preferred Name: _____ Gender: _____ Preferred Pronouns: _____

Lifestyle (Circle **ALL** that Apply): "I Am A... FULL-TIME PART-TIME CIVILIAN CADET ATHLETE RESIDENT COMMUTER "

PERSONAL HEALTH HISTORY – COMPLETED BY STUDENT (AND/OR PARENT OR LEGAL GUARDIAN IF PATIENT UNDER 18)

Medications: List all prescription and over-the-counter medicines and supplements (herbal and nutritional) you are currently taking:

Do you have allergies? No Yes If yes, identify specific allergen and describe the reaction:

Medicines Pollen Food Stinging Insects

Medical History: please list any relevant medical history (surgeries, concussions, mental health, ADD/ADHD, diabetes, asthma, etc)

All students are required to sign below, indicating they are aware that information on these medical forms may be shared between Norwich University Health Services, Norwich University Athletic Trainers and Norwich University Administration (including but not limited to the Dean of Students or Commandant.) The sharing of personal health information is to ensure that all medical professionals are familiar with each student's health history and help manage any treatment plans while the student is on campus. This authorization will expire when the student either withdraws or graduates from Norwich University.

Student Signature

Date Signed

Parent/Guardian Signature (if student under the age of 18, **please go to next section**)

Date Signed

Phone Number

If patient is under the age of 18, per Vermont Law [1 V.S.A. § 173], Norwich University Health Services, University of Vermont-Central Vermont Medical Center Health Network requires parental/guardianship consent to treat. Please fill out your information and then **check yes or no for each section granting consent to treat your student:**

Patient's parent and/or guardian, (Print Name) _____ (Relationship) _____, has given permission to treat patient through University of Vermont Health Network. Treatment includes:

Y N

Scheduling at Norwich University Health Services and UVM/Central Vermont Medical Center (non-emergency)

Medical Evaluation due to symptoms, diagnosis, medications, test results and treatment plan (does not include Mental Health unless specifically indicated with separate option)

Mental Health (Behavioral and Psychiatric) including symptoms, diagnosis, medications and treatment plan

*Patient's parent and/or guardian will get reached for patient's billing inquires/insurance, emergency visits (ED) and ambulatory, and medications listed/classified as control substances. **Permission remains in effect until patient's parent and/or legal guardian revokes it or patient turns 18 years old.***

