



HEALTH FORM

BETHEL COLLEGE WELLNESS CENTER

The wellness center joins together the Bethel College counseling services, student health services and the office of wellness programming. We are dedicated to helping meet the physical, emotional and spiritual needs of our students. Our goal is to extend God's compassion and healing power to our campus community by providing a broad range of preventive and problem-focused services from a Christian perspective. Our desire is that the services we offer meet the needs of the whole person. We seek to provide intentional growth experiences that are supportive and challenging so that each person may reach his/her God-given potential.

COUNSELING SERVICES

Confidential counseling services are available to all Bethel students. There is no cost for full-time students (12+ hours) and a minimal fee for part-time students. Call the wellness center for an appointment. Marriage/couple counseling, premarital counseling and personal counseling are available. Sessions usually last for 45 minutes. Most students will receive between four to eight sessions per school year. Students requiring more sessions will be referred to an area agency for counseling.

STUDENT HEALTH SERVICES

Student health services is a nurse-directed service that promotes health and wellness for Bethel students. Assessment and referral for ill and injured students is provided. Nurse visits are by appointment, but walk-ins are accepted. A dietitian is also available for nutrition consultation.

WELLNESS PROGRAMMING

The office of wellness programming provides educational programming and training for Bethel students at various times throughout the school year. The office of wellness programming also provides general health information and information on local health and mental health agencies.

HEALTH INSURANCE

Health insurance is required of all full-time students. Students having personal policies may opt to waive the college health insurance plan only by completing a signed waiver for the student development office within 15 days after classes begin. If the waiver is not submitted, students will be automatically enrolled in the Bethel student health insurance plan.

Bethel student health insurance claim forms are available at the wellness center. Students are responsible for any costs not covered by insurance. Additional information regarding the current student health plan is made available to all new students at registration.

ATHLETES

All student-athletes (recruits and walk-ons) will be required to have a complimentary sports physical held in the Wiekamp Athletic Center directed by the athletic trainers and certified sport doctors during the first week of school. This physical does not replace the required physical by all students before coming on campus. The cost of these physicals is covered by the athletic department. All student-athletes are also required to have secondary insurance, which is available through the college. Current fees for this policy are made available by the coaches and/or athletic trainers.

WELLNESS CENTER

574.807.7370 Fax: 574.807.7373

BethelCollege.edu/Wellness

Office Hours Monday, Tuesday, Thursday 8 a.m.-5 p.m.
Wednesday 8 a.m.-8 p.m.
Friday by appointment only

WELLNESS CHECKLIST

Health Form

- Medical history
- Physical examination
- Immunizations
- Consent for treatment

(Please make copies of all information for your files.)

Health Insurance

- Completed the Bethel student health insurance acceptance/waiver form

**All sections of the health form must be completed, signed and returned prior to your course registration to:
Student Health Services • Bethel College • 1001 Bethel Circle • Mishawaka, IN • 46545**

HEALTH FORM

A complete medical history is required of all traditional, undergraduate students. This information is kept confidential for the use of student health services and will not be released without written consent (except in an emergency).

**All immunizations must be current before moving into campus housing.
This completed form must be returned before registration.**



Name

Last

First

ID #

(Please print)

Name _____ Gender Male Female
Last First Middle (full) Maiden

Marital status Married Single Divorced Date of birth ____/____/____ Home phone (____)____
Month Day Year Area code Number

Home address _____
Street City State Zip code

Father's name (or spouse, if married) _____ Business phone (____)____
Area code Number

Address (if different) _____
Street City State Zip code

Mother's name _____ Business phone (____)____
Area code Number

Address (if different) _____
Street City State Zip code

Your physician _____ Phone number (____)____
Area code Number

Address _____
Street City State Zip code

Family History (to be filled out by student *before examination* and checked by physician)

Relation	Age	State of Health	Cause of Death	Age at death
Father				
Mother				
Siblings				
Has any blood relative had			Yes	No
Asthma, hay fever				
Kidney trouble				
Hypertension				
Diabetes				
Heart trouble				

PERSONAL HISTORY

Have you had?	Yes	No	Have you had?	Yes	No	Have you had?	Yes	No
ADD/ADHD			Headaches, frequent			Organ transplant		
Arthritis			Head injury			Pleurisy		
Anemia			Heart murmur			Poliomyelitis		
Appendicitis			Heart trouble			Rectal trouble		
Asthma			Hepatitis			Rheumatic fever		
Back trouble			High blood pressure			Scarlet fever		
Bloody urine			Histoplasmosis			Sinusitis		
Chicken pox			Irritable bowel syndrome			Skin disorder		
Chronic cough			Jaundice			Spitting blood		
Deafness			Kidney trouble			Tendency to bleed		
Diabetes			Measles			Thyroid trouble		
Earache			Meningitis			Tonsillitis		
Epilepsy/seizures			Menstrual problem			Tuberculosis		
Fainting spells			Migraine			Ulcer		
German measles			Mononucleosis			Whooping cough		
Hay fever			Mumps			Other disorders (list below*)		

*Other disorders or illnesses (list) _____

Do you have a history of any chemical dependency (including alcohol), eating disorder (including anorexia or bulimia), depression or any mental health problem? Please explain _____

Injuries, surgeries, fractures, etc. (include date of occurrence) _____

Allergy to drugs, food, plants, others _____

Medication taken regularly _____

Absence of paired organ (kidney, eyes, reproductive organs, etc.) _____

Date of last dental exam (recommended before coming to campus) _____

- I certify that the above information is complete and accurate.
- I have reviewed the accompanying information on meningococcal meningitis. I understand that the meningitis vaccine offers protection against certain strains of Neisseria Meningitis and is recommended for students in residence halls and that the vaccine is available through physicians offices, clinics and local health departments.
- I authorize the release of medical information to my parent(s) or legal guardian as deemed necessary by the Student Health Services staff for medical treatment and follow-up care.

Student signature _____ Date _____

Parent signature _____ Date _____

(MUST be signed by parent if student is under age 18)

PHYSICAL EXAMINATION

TO BE COMPLETED BY YOUR PRIMARY HEALTHCARE PROVIDER

Student's name _____ Date of birth _____ / _____ / _____ Date of exam _____ / _____ / _____
Month Day Year Month Day Year

Blood pressure _____ Pulse _____ Weight _____ Height _____

Student athletes, have you been assured a position on an athletic team by a Bethel coach? Yes No If yes, what sport? _____

Normal	Abnormal	Check appropriately and describe abnormality		Normal	Abnormal
		Head, scalp, face	Abdomen		
		Eyes	Genitalia (pelvic if indicated)		
		Ears, nose, throat	Rectal (if indicated)		
		Teeth	Hernia		
		Neck/thyroid	Adenopathy		
		Chest & lungs	Skin		
		Heart	Extremities & joints		
		Urinalysis (if indicated)	Neurological		
		Breasts (if indicated)	Emotional status		

IMMUNIZATION STATUS

Proof of immunity is required prior to class attendance at Bethel College. Specify month/day/year.

REQUIRED

Meningococcal vaccine _____ (mo/day/yr)

Diphtheria-Tetanus-Pertussis

Initial series completed _____ (mo/day/yr)
 Booster within last 10 yrs. _____ (mo/day/yr)
 Td/Tdap (circle one)

MMR (Measles, Mumps, Rubella)

#1 After age 12 mo. _____ (mo/day/yr)
 #2 Booster 30 days after initial _____ (mo/day/yr)

Polio

Type of vaccine Oral Injectable
 Initial series completed _____ (mo/day/yr)
 Last booster _____ (mo/day/yr)

RECOMMENDED

Hepatitis B #1 _____ (mo/day/yr)
 #2 _____ (mo/day/yr)
 #3 _____ (mo/day/yr)

Hepatitis A #1 _____ (mo/day/yr)
 #2 _____ (mo/day/yr)

Varicella

#1 _____ (mo/day/yr)
 #2 _____ (mo/day/yr)
 or history of disease

Tuberculosis (TB)

*Please complete the **TUBERCULOSIS SCREENING FORM** (next page). If you answer "yes" to any questions on the TB Screening Form, you **MUST** have a TB skin test administered in the United States within 6 months of entering Bethel.*

PPD (Mantoux) test within the last 6 months (Tine or Monovac not acceptable):

Date given _____ (mo/day/yr)
 Date read _____ (mo/day/yr)
 Read by _____ Results _____ mm

Chest x-ray (required if positive PPD; include x-ray report)

_____ (mo/day/yr) Positive Negative
 BCG vaccine (not required) _____ (mo/day/yr)

I have verified immunization records Yes No

Physician _____ Title/degree _____
First name Last name

Address _____
Street City State Zip code

Signature _____ Phone (_____) _____
Area code Number

TUBERCULOSIS SCREENING FORM

Please answer the following questions.	Yes	No
Have you ever had a positive TB skin test?		
Have you ever had close contact with anyone who was sick with TB?		
Were you born in one of the countries listed below? (If Yes, please list the country).		
Have you ever traveled* to/in one or more of the countries listed below? (If Yes, please list the country(ies)).		
Have you ever been vaccinated with BCG?		
Are you immunocompromised? (e.g., HIV, cancer, etc.)		
Have you been in a homeless shelter or correctional institution for more than 72 hours in the last 12 months?		

If the answer is **Yes** to any of the above questions, Bethel College requires that a **health care provider complete a tuberculosis risk assessment and TB skin test** (to be completed six months prior to the start of classes). If the answer is **No**, no further testing or further action is required.

**The significance of the travel exposure should be discussed with a health care provider and evaluated.*

COUNTRY LIST

Afghanistan, Algeria, Angola, Argentina, Armenia, Azerbaijan, Bahrain, Bangladesh, Belarus, Belize, Benin, Bhutan, Bolivia (Plurinational State of), Bosnia & Herzegovina, Botswana, Brazil, Brunei Darussalam, Bulgaria, Burkina Faso, Burundi, Cambodia, Cameroon, Cape Verde, Central African Republic, Chad, China, Colombia, Comoros, Congo, Cote d'Ivoire, Democratic People's Republic of Korea, Democratic Republic of the Congo, Djibouti, Dominican Republic, Ecuador, El Salvador, Equatorial Guinea, Eritrea, Estonia, Ethiopia, Fiji, French Polynesia, Gabon, Gambia, Georgia, Ghana, Guatemala, Guinea, Guinea-Bissau, Guyana, Haiti, Honduras, India, Indonesia, Iran (Islamic Republic of), Iraq, Japan, Kazakhstan, Kenya, Kiribati, Kuwait, Kyrgyzstan, Lao People's Democratic Republic, Latvia, Lesotho, Liberia, Libya, Lithuania, Madagascar, Malawi, Malaysia, Maldives, Mali, Marshall Islands, Mauritania, Mauritius, Mexico, Micronesia (Federated State of), Mongolia, Morocco, Mozambique, Myanmar, Namibia, Nauru, Nepal, Nicaragua, Niger, Nigeria, Niue, Pakistan, Palau, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Poland, Portugal, Qatar, Republic of Korea, Republic of Moldova, Romania, Russian Federation, Rwanda, Saint Vincent & the Grenadines, Sao Tome & Principe, Senegal, Serbia, Seychelles, Sierra Leone, Singapore, Solomon Islands, Somalia, South Africa, South Sudan, Sri Lanka, Sudan, Suriname, Swaziland, Tajikistan, Thailand, Timor-Leste, Togo, Trinidad & Tobago, Tunisia, Turkey, Turkmenistan, Tuvalu, Uganda, Ukraine, United Republic of Tanzania, Uruguay, Uzbekistan, Vanuatu, Venezuela (Bolivarian Republic of), Viet Nam, Yemen, Zambia, Zimbabwe

CONSENT FOR MEDICAL AND MENTAL HEALTH TREATMENT OF A MINOR CHILD

FOR STUDENTS WHO WILL BE UNDER 18 YEARS OF AGE WHEN STARTING CLASSES

I (We) do hereby state that I am (we are) the parent(s) or legal guardian(s) of _____, *Student name*
 a minor born / / , who is a student at Bethel College, Mishawaka, Ind.
Month Day Year

I (We) do hereby give consent to any necessary emergency examination, anesthetic, medical diagnosis, surgery or treatment, and/or hospital care to be rendered to the above-named minor under the general or special supervision and on the advice of any physician or surgeon licensed to practice medicine.

I (We) do hereby give consent to any necessary emergency mental health evaluation, treatment, and/or hospital care to be rendered to the above-named minor under the general or special supervision and on the advice of any physician, psychologist or counselor licensed to practice medicine, psychotherapy or counseling.

I (We) understand this is to be used only if I (we) cannot be reached. I (We) understand this is to allow emergency treatment to be initiated without delay and the staff will continue efforts to contact me (us).

This consent will be valid as long as the above-named is a minor and a student at Bethel College.

Signature(s) of parent(s) or guardian(s)

Date

Signature(s) of parent(s) or guardian(s)

Date

OVERVIEW OF MENINGOCOCCAL DISEASE

MENINGOCOCCAL INFORMATION

Meningococcal disease is an acute bacterial infection that strikes nearly 3,000 Americans each year. Adolescents and young adults are particularly vulnerable to the disease, accounting for nearly 30 percent of all cases in the U.S. A recent study found one in four adolescents infected will die, and those who survive, up to 20 percent will experience permanent disability.

Meningococcal disease, although rare, is devastating because early symptoms resemble the flu, making it difficult to recognize. However, unlike the flu, the disease can progress rapidly and within hours of initial symptoms may cause hearing loss, brain damage, limb amputation and even death. Symptoms include high fever, headache, stiff neck, confusion, nausea, vomiting and exhaustion. In later stages, a rash may appear. Adolescents and young adults should seek medical attention immediately if they notice unusually sudden or severe symptoms of the disease.

The infection usually manifests itself as an inflammation of the membranes around the brain and spinal cord (meningococcal meningitis) or an infection of the blood (meningococemia), and they are caused by the same bacteria (*Neisseria meningitidis*).

Meningococcal bacteria are transmitted through the air droplets of respiratory secretions and direct contact with the persons infected with the disease.

MENINGOCOCCAL DISEASE PREVENTIONS

The Centers for Disease Control and Prevention (CDC) issued recommendations calling for routine vaccination with meningococcal conjugate vaccine for college freshmen living in residence halls. College freshmen living in residence halls are at higher risk for meningococcal disease compared to other people of the same age. Additionally, CDC states all other adolescents and college students wishing to reduce their risk may elect to be immunized if they have not previously been vaccinated. The American Academy of Pediatrics, American Academy of Family Physicians and the American College Health Association also supports these recommendations.

The meningococcal meningitis vaccine offers protection against certain strains of *Neisseria Meningitidis*. Meningitis vaccines are available through your family physician or clinics.

Adolescents and young adults should also be aware of other ways to reduce their risk of contracting the disease, including not sharing beverages or utensils, and regular sleeping patterns.

The following are websites that provide more information about meningococcal disease and immunization

- National Meningitis Association, nmaus.org
- Centers for Disease Control and Prevention, cdc.gov
- American Academy of Pediatrics, aap.org
- American Academy of Family Physicians, aafp.org
- American College Health Association, acha.org
- National Foundation for Infectious Diseases, nfid.org

This information is accurate as of 2015 and is subject to change. This is intended for general information purposes only – please consult your primary care provider.

STUDENT HEALTH SERVICES **FAQS**

What health information is required before registration?

- Health form including:
 - Medical history completed by student and family
 - Physical examination completed by family healthcare provider
 - Consents for medical and mental health treatment of a minor signed by parent or guardian
 - Immunization record completed on health form (*see required proof of vaccines below*)
- Contact student health services to make arrangements if unable to meet registration deadline.

Which immunizations are required?

- Childhood diphtheria, pertussis and tetanus series
- Tetanus booster in the last 10 years
- Measles, mumps, rubella (two doses after age one year)
- Polio series

Which immunizations are recommended?

- Hepatitis A series
- Hepatitis B series
- Meningitis (*see section on meningitis*)
- Varicella (chicken pox) or indicate date of disease

What if I cannot find my immunization records?

- You may be required to get blood tests (titers) to show proof of immunity.
- You may need to get boosters at the local health department (*low cost at student's expense*).

Where can I find my immunization (shot) records?

- Check with your high school
- Check with your doctor or clinic
- Check with your local health department

I've read the meningitis information and I'm interested in the vaccine.

- The meningitis vaccine is available at the local health department (St. Joseph County, Ind.) for a fee. Call early for an appointment – there may be a waiting list.
- Check with your health care provider or local health department.

Which students need to complete a physical examination?

- All new students, freshmen and transfers
- Any new student under age 25 or any residential student
- Or as determined by student health services director

Do I need a physical every year?

- No, just initially, unless your health changes or as determined by student health services director.
- Nursing students must have an annual physical.

Do athletes need to get a physical before coming on campus?

- Yes. Athletes that will be practicing, conditioning or competing before mandatory athletic physicals are given, will need a physical prior to coming to campus.

Who is required to show proof of a TB (tuberculosis) skin test?

- International students
- Anyone who
 - Has traveled or was born out of the country
 - Worked in a nursing home, hospital or daycare
 - Worked or lived in a prison or homeless shelter
 - Been exposed to someone with tuberculosis
 - Or as determined by student health services director

All students are required to have health insurance. What about the Bethel student health insurance plan?

- All full-time traditional students are automatically enrolled in the Bethel College student health insurance plan unless a signed waiver is on file in the student development office.
- Waiver deadline ends 15 business days after classes begin (fall and spring semester).
- See the Bethel student health insurance brochure for more details of coverage/exclusions. Information is subject to change.
- Students not enrolled in the Bethel student health insurance plan must have their current health insurance coverage information on file in the student development office.
- All students should keep their current health insurance card and their photo I.D. with them on campus.
- **Students are responsible for any costs not covered by insurance.**



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