HARTWICK COLLEGE
est. 1797

Physical Examination Form

Must be completed by physician, nurse practitioner, or physician's assistant.

Questions? Call Perrella Health Center at 607-431-4120.

WE REQUIRE THAT THE PHYSICAL EXAMINATION BE COMPLETED WITHIN 12 MONTHS OF THE START OF THE ACADEMIC YEAR.
ATHLETE PHYSICALS MUST BE COMPLETED WITHIN 6 MONTHS OF FIRST PARTICIPATION.

Student name _____ Date of Birth ____/____/____ Date of Exam ____/____/____

Gender: _____

Age: _____

Blood pressure: _____

Pulse: _____

Height: _____

Weight: _____

Vision: _____

Far: Right 20/ _____

Corr. to 20/ _____

Far: Left 20/ _____

Corr. to 20/ _____

Any operations, serious injuries, or serious illness not noted at right?

_____

_____

Restrictions (specify):

_____

_____

Clinical Evaluation	Normal	Abnormal	Please comment on all abnormal
1. Skin			
2. HEENT			
3. Lymphatic			
4. Respiratory			
5. Cardiovascular			
6. Musculoskeletal			
7. Hernia			
8. Abdomen			
9. GU			
10. GYN date last pap smear: ____/____/____			
11. Neurological			
12. Orthopaedic A. Shoulders	L ____ R ____	L ____ R ____	
B. Knees	L ____ R ____	L ____ R ____	
C. Ankles	L ____ R ____	L ____ R ____	
13. History of Covid 19	Date of diagnosis: ____/____/____		

By signing below I acknowledge review of the medical history pg 2 and completion of physical examination form. This student is able to engage in required physical education program and contact sports unless otherwise indicated. If a nursing major, student is medically cleared to wear respiratory protection and is in satisfactory condition to care for clients.

_____ _____
Name of healthcare provider (print) **Telephone**

_____
Address (street, city, state, zip)

_____ ____/____/____
Signature of healthcare provider **Date**

HARTWICK COLLEGE

Authorization and Consent for Treatment

This form must be signed by THE STUDENT OR by BOTH the PARENT/GUARDIAN AND STUDENT if the student will be under the age of 18 at the time of arrival to the Hartwick College Campus. Once completed this form must be uploaded to the student's health portal.

- I grant permission for the Hartwick College medical staff or whomever he/she may designate to evaluate and treat all injuries or illnesses for which help is sought for the individual named on this form. In the case of a minor student (under the age of 18), this treatment may proceed without prior notification of the undersigned parent or guardian.

- In the event that I am unable to indicate consent and a parent or guardian is unable to be reached or there are time constraints regarding my care, I give permission for the Hartwick College medical staff to obtain consultative care that may include hospitalization, anesthesia, surgery, and/or other medical treatment as deemed necessary.

- I agree that needed immunizations or testing may be completed and that the Hartwick College medical staff may release information to other health care providers who are involved in my care. If I am enrolled in the nursing major, I authorize release of any pertinent information regarding my clearance to safely participate in clinical activities, the date of my annual physical, my annual tuberculosis screening, and my immunization records to the Hartwick College Nursing Department and any clinical facilities where I will be a student. If I am a NCAA athlete, I give permission for my annual sports history and physical and any information regarding illness or injury that is pertinent to my athletic participation to be shared with the sports medicine staff, my coach, and the athletic administrative staff as deemed appropriate by the Perrella Medical Staff.

- I am aware that the Perrella Health Center charges for some services and authorize these charges to be billed to the student account. I accept responsibility for settling the account and payment of incurred charges. If my account has a credit balance from my Title IV Federal funds, I give permission to use these funds to cover the charges. This includes charges for medications from the in-house formulary, equipment, point of care lab testing, minor procedures, and missed appointments without prior notification.

- I am aware that should I need copies of my medical record, there may be a charge.

- I am aware that HIV testing can be ordered by the providers at the Perrella Health Center and that I may request this testing at any time.

Student Signature: (required)

_____ Date:_____

Student Printed Name:

_____

Parent/Guardian Signature: (required if the student is under 18)

_____ Date:_____

HARTWICK COLLEGE

Health Information Use and Disclosure

To be completed by student and parent or guardian.

_____ ____/____/____

Student Name *Date of Birth*

This form authorizes the use and disclosure of individually identifiable health information to the Bassett Healthcare Network of Providers.

The Perrella Health Center at Hartwick College utilizes an electronic medical record-keeping system (EMR) in affiliation with the Bassett Healthcare Network. This system allows the Perrella Health Center and/or the Bassett Healthcare Network of Providers to access different components of any patient's "chart" and also provide up-to-date information to any provider in the Bassett Healthcare Network who might see patients on an emergency basis and/or when our clinic is closed. The Perrella Health Center also can promptly access test results as they are completed, bypassing clerical turnaround times. EMR is a welcome addition at the Perrella Health Center as we strive to provide efficient, comprehensive healthcare to our students.

1. I authorize the use and/or disclosure of my health information as described below.

2. My health information will be shared only between the Perrella Health Center and the Bassett Healthcare Network of Providers to facilitate continuity of care in the event I require treatment by the Fox Hospital Emergency Department or FoxNow walk-in clinic. It also will be available to Bassett Network affiliated specialists if I should require their services. This also will enable the Perrella Health Center to access my test results (laboratory tests, x-rays, cultures, etc.) in a timely manner in order to expedite my care.

3. I understand that the information in my health record may include information regarding the use of drug and alcohol treatment services, HIV/AIDS treatment, mental health services, reproductive health services, and treatment for sexually transmitted diseases.

   Note: Psychotherapy records from our College counselors, other than referrals to our providers, may be used/disclosed only pursuant to a separate signed authorization pertaining only to psychotherapy records.

4. I understand that the information I authorize to be used or disclosed may be used only within the Bassett Healthcare Network of providers, but may be subject to re-disclosure. Re-disclosure designates that the information is no longer protected under federal privacy regulations. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

5. I understand that this authorization is subject to revocation at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Perrella Health Center at Hartwick College. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the date of graduation or other official permanent separation from the College.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization, but do acknowledge that by refusing to authorize, communication may be delayed. I understand that I need not sign this form to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided by the CFR 164.524. If I have any questions about disclosure of my health information, I can contact the director of the Perrella Health Center by calling 607-431-4120.

Student name (please print)	**Signature of student (or person authorized to consent for student)**	**Date signed** ____/____/____
Parent/guardian name if student is under 18 years of age (please print)	**Signature of Parent/guardian**	**Date signed** ____/____/____
Signature of staff person at Perrella Health Center	**Title**	**Date signed** ____/____/____