



VALLEY FORGE MILITARY ACADEMY & COLLEGE
HEALTH CENTER
OVERVIEW

Dear Parent(s)/Guardian:

On behalf of the Health Center Staff, we would like to welcome your cadet to VFMA&C and provide a brief overview of some of our services. The Health Center is open 24 hours a day for emergency care and provides nursing services during sick call hours and appointed times. We have a physician available Monday through Friday by appointment and 24 hour phone consultation.

At the physician's discretion he will order treatments, medications, lab testing, outside referrals, and hospitalizations if required. For cause, drug and alcohol screening may also be ordered. All occurred expenses are billed to the parent(s)/guardian.

We will gladly schedule an outside appointment and provide local transportation (for a nominal fee). **IF YOU ARE AN HMO PARTICIPANT, IT WILL BE YOUR RESPONSIBILITY TO OBTAIN CLEARANCE FROM YOUR PRIMARY PHYSICIAN FOR OUTSIDE REFERRALS.** You will be notified of all outside consultations, emergency and hospitalizations.

IMMUNIZATION RECORDS ARE MANDATORY. Send all medical related information directly to the Health Center. **NO EXCEPTIONS WILL BE MADE. Do not assume records are forwarded from transferring school or military institutions.**

ALL CADETS MUST BE COVERED BY ACTIVE MEDICAL INSURANCE. **COVERAGE THROUGH THE PLAN AT VFMA&C IS AVAILABLE TO CADETS WHO DO NOT SUBMIT PROOF OF VALID MEDICAL INSURANCE.** If your Cadet needs to be covered by student health insurance, a brochure is available through the Business Office. **PLEASE BE AWARE OF THE LIMITATIONS OF THE POLICY.** International Cadets are required to purchase VFMA&C's insurance. In the event of an emergency or need for hospitalization or outside consultant's, a copy of the medical/prescription insurance card is **MANDATORY.** Please send a photocopy of the card (front & back) with Health Center paperwork.

ALL NEW AND RETURNING CADETS are required to have on file with the Health Center a full and satisfactory **PHYSICAL EXAMINATION** completed after **1 June 2008.** The Physical exam **MUST** include all components. **The PPD test (tuberculosis screening) must be completed annually.** The Health Center will accept exams completed on VFMA&C HEALTH CENTER FORMS ONLY. **PLEASE BE AWARE: DUE TO PRIVACY LAWS WE ARE UNABLE TO OBTAIN COPIES OF ROTC AND DODMERB PHYSICALS.**

The Pennsylvania School Health Law also requires a dental examination for all new students on entry to school and 7th grade. Students transferring from another school should be examined to provide an adequate dental record if one is not made available by the original school. We recommend your child's private dentist perform this evaluation since he/she can best evaluate your child's teeth. Please return the dental form along with the physical exam.

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HEALTH CENTER **OVERVIEW**

In the event your Cadet needs to return home for any reasons, a SPECIAL MEDICAL LEAVE FORM should be completed as soon as possible. The MEDICAL LEAVE request is initiated first with the Cadet's Tactical Officer; the Health Center department will then approve the leave. Cadet must sign out from the Health Center and receive a referral form to be completed by the Medical Specialist prior to return back to school.

CADETS MAY NOT HAVE ANY MEDICATION, WHETHER OVER THE COUNTER (to include vitamins) OR PRESCRIPTIONS IN THE BARRACKS. Use of unapproved herbal or dietary supplements is prohibited. A waiver form is available to allow for supplements/proteins to be stored and administered at the Health Center. All medication vitamins and protein supplements must have the approval from the Medical Director and Director of the Health Center **prior** to reporting to school.

The Health Center will NOT accept ANY unlabeled medications. **AT NO TIME SHOULD A CADET HAVE ANY UNAUTHORIZED MEDICATIONS IN HIS POSSESSION.** All Cadets taking medication on a regular basis must be enrolled in the MMP (Medication Management Program) to assure compliance. The information regarding our program is available on request. Please consult fee schedule for charges pertaining to Medication Management Program.

The Health Center stocks many routinely used medications. In the event your Cadet requires a medication not available on campus, arrangements can be made to obtain it. The Health Center has retained the services of Babis Pharmacy to fulfill the prescription needs of the Cadets. A nurse will contact you to make arrangements through Babis Pharmacy to purchase and deliver the required medication to the Health Center.

All Cadets are expected to fully participate in all physical activities. All conditions requiring specific restrictions from physical activities must be documented by the cadet's physician, and accepted by the Director of Health Center and Medical Director prior to arrival. Conditions not disclosed on the Medical Forms or to the Health Center Staff that could adversely affect the cadet's health and performance are not to be the responsibility of the school and may result in dismissal.

We look forward to your Cadet's arrival on campus. We will do all we can to assist in a successful school year. Safety and wellness are our ultimate goal for these very deserving Cadets. We thank you in advance for your review and timely completion of ALL FORMS.

VALLEY FORGE MILITARY ACADEMY & COLLEGE
HEALTH CENTER STAFF

Patricia A. Quinn, R.N.
Director of Health Center

Rocklan D. Walker, D.O.
Medical Director



**VALLEY FORGE MILITARY ACADEMY & COLLEGE
DEPARTMENT OF HEALTH SERVICES**

FORMS CHECK LIST

ANNUALLY, PRIOR TO CADETS ARRIVAL ON CAMPUS, ALL FORMS MUST BE COMPLETED AND SUBMITTED DIRECTLY TO THE HEALTH CENTER, IN ENVELOPE PROVIDED.

- _____ CADET CONSENT FOR TREATMENT/ WITH PARENT SIGNATURE (PG 4)
- _____ MEDICAL HISTORY (PG 5)
- _____ PHYSICIAN HISTORY, PHYSICAL EXAM TO BE COMPLETED (PG 6)
- _____ SCOLIOSIS SCREEN (MANDATORY FOR 7TH GRADE) (PG 6)
- _____ HEARING EXAMINATION (7TH & 11TH GRADE) (PG 6)
- _____ VISION (PG 6)
- _____ URINALYSIS (PG 6)
- _____ IMMUNIZATION FORM WITH PRIMARY CARE PROVIDERS NAME, ADDRESS, PHONE NUMBER, SIGNATURE, AND PRACTITIONER'S STAMP (PG 7)
- _____ HEALTH INSURANCE FORM (PG 8)
- _____ MEDICAL/DENTAL/PRESCRIPTION CARD COPIES (FRONT& BACK)
- _____ NOTICE OF PRIVACY PRACTICES (PGS. 9 & 10)
- _____ HIPPA ACKNOWLEDGEMENT FORM (PG 11)
- _____ AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (**FOR 18 AND OLDER**) (PG 12)
- _____ DENTAL FORM FOR ALL NEW STUDENTS AND 7TH GRADE (PG 13)

IF THERE ARE ANY QUESTIONS PLEASE CONTACT THE HEALTH CENTER AT 610-989-1517 OR 610-989-1518.

CADET CONSENT FOR MEDICAL TREATMENT

**ALL FORMS MUST BE COMPLETED, SIGNED AND RETURNED TO THE HEALTH CENTER BEFORE/PRIOR
YOUR CADET ARRIVES ON CAMPUS**

NAME _____
(LAST) (FIRST) (MIDDLE)

DATE OF BIRTH _____ SOCIAL SECURITY NO _____

ADDRESS _____
(NUMBER AND STREET)

(CITY) (STATE) (ZIP CODE)

MOTHER'S NAME _____

PHONE (H) (____) _____ (W)(____) _____ Mobile() _____

FAX NUMBER Home (____) _____ Office (____) _____

FATHER'S NAME _____

PHONE (H) (____) _____ (W)(____) _____ Mobile() _____

FAX NUMBER Home (____) _____ Office (____) _____

EMERGENCY CONTACT (OTHER THAN PARENTS) _____

PHONE (H) (____) _____ (W)(____) _____ Mobile() _____

FAX NUMBER Home (____) _____ Office (____) _____

RELEASE STATEMENT

I DO HEREBY GIVE PERMISSION FOR THE VALLEY FORGE MILITARY ACADEMY AND COLLEGE HEALTH CENTER STAFF AND/OR CONSULTANTS APPROVED BY THEM TO TREAT MY CADET _____ ON A ROUTINE OR EMERGENCY BASIS. I ALSO GIVE MY PERMISSION FOR HIS/HER REFERRAL TO BRYN MAWR HOSPITAL FOR EVALUATION AND TREATMENT AS DEEMED NECESSARY FOR HIS/HER WELL BEING. I ALSO UNDERSTAND THAT SHOULD SUCH A REFERRAL BE NECESSARY, I WILL BE NOTIFIED AS SOON AS POSSIBLE. FOR MY STUDENT ATHLETE, I GIVE PERMISSION FOR TREATMENT BY CERTIFIED ATHLETIC TRAINER AND OR SPORTS MEDICINE PRACTITIONER CONTRACTED BY VALLEY FORGE. I WILL PROVIDE A COMPLETE HEALTH AND IMMUNIZATION RECORD TO THE HEALTH CENTER BEFORE HIS/HER ARRIVAL ON CAMPUS. I UNDERSTAND THAT IF THESE ARE NOT COMPLETE IN ACCORDANCE WITH PA STATE LAW THEY WILL BE ADMINISTERED WITHOUT FURTHER NOTICE AT VFMA&C HEALTH CENTER AT AN ADDITIONAL COST TO YOU. I FULLY UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AND ALL EXPENSES INCURRED IN THE MEDICAL, SURGICAL, PSYCHIATRIC, DENTAL AND PODIATRIC TREATMENT OF MY CADET.

I DO HEREBY GIVE PERMISSION FOR VALLEY FORGE MILITARY ACADEMY AND COLLEGE, DEPARTMENT OF HEALTH SERVICES, TO RELEASE AND RECEIVE PROTECTED HEALTH INFORMATION REGARDING MY CADET; FOR THE PURPOSE OF BUT NOT LIMITED TO, COMPLETION OF ALL REQUIRED MEDICAL/PSYCHIATRIC RECORDS AND PERTAINING TO REFERRALS MADE TO CONSULTANTS, LABS, HOSPITALS INVOLVED IN HIS CARE. DEPARTMENT OF HEALTH SERVICES MAY REVIEW/RELEASE PERTINENT MEDICAL/DRUG TEST RESULTS TO VFMA&C ADMINISTRATION.

I FURTHER UNDERSTAND THAT IF ANY INFORMATION ON THIS FORM IS FALSE, MISLEADING, OR OMITTED WHICH IN THE OPINION OF THE SCHOOL WOULD HAVE REFLECTED ADVERSELY ON THE DECISION FOR ACCEPTANCE, THE SCHOOL, AT ITS DISCRETION, MAY DISMISS MY CADET. I HAVE READ AND FULLY UNDERSTAND THE HEALTH INFORMATION AS SUBMITTED BY VALLEY FORGE MILITARY ACADEMY AND COLLEGE.

PARENT OR GUARDIAN'S SIGNATURE _____ DATE _____

CADET SIGNATURE (IF OVER 18) _____ DATE _____

CADET MEDICAL HISTORY

CADET NAME _____

MEDICATIONS AND VITAMINS THAT YOUR CADET IS CURRENTLY TAKING

MEDICATION	DOSE	SCHEDULE	HEALTH CARE PROVIDER (Including Phone #)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICAL HISTORY –Does your Cadet HAVE or has your Cadet EVER HAD any of the following conditions: (please check)

YES	NO		YES	NO		YES	NO	
___	___	Abdominal Pain (Chronic)	___	___	Fatigue (chronic)	___	___	Psychiatric Treatment
___	___	Anemia/ Thalasemia	___	___	Fracture	___	___	Psychological Counseling
___	___	Appendicitis/Appendectomy	___	___	Gulliane Barre	___	___	Rubella/German Measles
___	___	ADD	___	___	Headaches (recurrent)	___	___	Seizures
___	___	ADHD	___	___	Head Injury/ Concussion	___	___	Sinus Infections (recurrent)
___	___	Asthma/Wheezing	___	___	Hearing Loss	___	___	Skin Disorders
___	___	Bleeding Disorder	___	___	Heart Disease	___	___	Spleen Injury/ Splenectomy
___	___	Bronchitis	___	___	Heart Murmur	___	___	Stinger/Burner
___	___	Bursitis	___	___	Heat Related Illness	___	___	Tendonitis
___	___	Chicken Pox	___	___	Hepatitis/ Jaundice	___	___	Tobacco Users
___	___	Congenital Abnormality	___	___	High Blood Pressure	___	___	Tuberculosis
___	___	Cancer	___	___	Indigestion	___	___	Ulcer
___	___	Concussion	___	___	Immune Disease	___	___	Urinary Tract Infection
___	___	Depression	___	___	Kidney Disease	___	___	Vision Problems
___	___	Diabetes	___	___	Measles	___	___	Endometriosis
___	___	Dislocation	___	___	Migraines	___	___	Alcohol/Drug Additions
___	___	Dizziness/ Fainting	___	___	Mononucleosis			
___	___	Ear infections (chronic)	___	___	Mumps			
___	___	Eating Disorders	___	___	Neurological Disease			
___	___	Enuresis (bedwetting)	___	___	Pneumonia			

Explain any YES answers _____

YES	NO	
___	___	MEDICATION ALLERGIES? LIST _____
___	___	Any other allergies? LIST _____
___	___	A negative reaction to a vaccination? Explain _____
___	___	A positive TB test reaction. (Chest X-Ray must be provided) Explain _____
___	___	Prior hospital admissions? Explain _____
___	___	Any type of surgery? Explain _____
___	___	Any serious illness/injury without hospitalization? Explain _____
___	___	Has anyone in the family died of cardiac problems before the age of 50? Relationship to cadet _____
___	___	Family History of Marfan Syndrome? Relationship to cadet _____
___	___	Needed to use an Inhaler? How often? _____
___	___	Any unexplained loss of consciousness? Explain _____
___	___	Significant absenteeism from school because of illness? Explain _____
___	___	Restriction for sports participation or physical activity due to illness or injury within the past 3 years? Explain _____
___	___	Treatment or counseling for an emotional/psychiatric problem within 3 years? Explain _____
___	___	Any physical or emotional disability? Explain _____
___	___	Any condition requiring a specialized physical education program? Explain _____
___	___	Any other significant past medical history? Explain _____



VALLEY FORGE MILITARY ACADEMY & COLLEGE HEALTH CENTER
1001 EAGLE ROAD, WAYNE, PA 19087
PHONE 610-989-1517/18 FAX 610-989-1516

PHYSICAN HISTORY, PHYSICAL EXAMINATION AND PROOF OF IMMUNIZATION

Name of cadet: _____ **DOB:** _____

Address: _____ **Phone:** _____

Allergies: (Please list all allergies to medication, foods, bees, contrast dye, vaccines, etc.)

Past medical history: (Please include all surgeries, hospitalizations, any serious illness and psychiatric issues.)

Family history: (Please explain any "yes" answers in the space provided.)

Is there any history of tuberculosis exposure? _____

Is there any history of sudden death at a young age of parents, siblings, grandparents, cousins, aunts or uncles? _____

Is there any history in the parents or siblings of childhood diseases, diabetes, heart disease, seizures or cancer? _____

Social history: (Please list any history of tobacco, alcohol or drug use, marital status of parents or guardianship.)

Medications: (Please list current medications and any past medications used on a regular basis.)

Physical Examination: Ht. _____ Wt. _____ B/P _____ Pulse _____

_____ **Normal complete physical exam that includes: emotional status, HEENT, heart, lungs, abdomen, G/U neurological, skin, musculoskeletal.**

_____ **Complete physical exam with the following abnormalities:** _____

Audiometer Hearing Screening (Mandatory for 7th & 11 graders): _____ NORMAL _____ ABNORMAL

Vision: 20/____ OS 20/____ OD corrected _____ uncorrected _____

Urinalysis: Protein _____ Glucose _____

Scoliosis Test (Mandatory for 7th Grade): _____ Normal/Spine _____ Scoliosis

Indicate treatment plan if applicable: _____

NAME OF CADET _____

ALL STUDENTS MUST PROVIDE IMMUNIZATION RECORDS BEFORE REPORTING. STUDENTS WHO DO NOT HAVE THE DOCUMENTED MINIMUM REQUIRED IMMUNIZATIONS WILL NOT BE ALLOWED TO REMAIN ON CAMPUS. MONTH AND YEAR MUST BE INCLUDED. ATTACHED COPIES WILL NOT BE ACCEPTED!

IMMUNIZATION RECORD

Enter month, day and year each immunization was given					
VACCINE	BASIC SERIES DATES OF DOSES AND BOOSTERS				
Diphtheria and Tetanus* (DTaP, DTP, Td or DT)	1 / /	2 / /	3 / /	4 / /	5 / /
Polio (OPV or IPV)	1 / /	2 / /	3 / /	4 / /	5 / /
Hepatitis B	1 / /	2 / /	3 / /	4 / /	
Measles, Mumps, Rubella (MMR)	1 / /	2 / /	Or Measles Serology: Date _____ Titer _____		
Varicella	1 / /	2 / /	Rubella Serology: Date _____ Titer _____		
Other	1 / /	2 / /	Mumps disease diagnosed by a physician: Date _____		

MENINGOCOCCAL VACCINE (ONE REQUIRED FOR ALL CADETS) ___/___/___

_____ **MEDICAL EXEMPTION** (The physical condition of the cadet is such that immunization would endanger life or health)

_____ **RELIGIOUS EXEMPTION** (Includes a strong moral or ethical conviction similar to a religious belief and requires a written statement from the parent/guardian)

TUBERCULIN TEST DATE: ___/___/___/ (Mandatory last 6 months) **RESULT:** _____ mm.

If positive, results of a chest x-ray within the last six months is required: _____

Preventive Anti-Tuberculosis Chemotherapy (INH) ordered. _____ Date ___/___/___
(YES) (NO)

Cadets at VFMA &C undergo vigorous physical conditioning. By signing below, I certify that the above information is correct and that the cadet is fully capable of participating in all activities of the institution including, but not limited to, physical education, fitness training and all athletic activities.

Print Physician's Name _____ **Physician's Stamp:** _____
Address _____
Phone () _____ **Fax** () _____

Physician Signature: _____ **Date of Exam:** _____

HEALTH INSURANCE

ALL CADETS MUST HAVE HEALTH AND ACCIDENT INSURANCE. COVERAGE THROUGH VALLEY FORGE MILITARY ACADEMY AND COLLEGE IS AVAILABLE TO CADETS WITHOUT PROOF OF VALID MEDICAL INSURANCE.

CADET NAME _____ DATE OF BIRTH _____

Please check which services are covered under the insurance information listed below.

Medical _____ Prescription _____ Dental _____

NAME OF INSURANCE CARRIER _____

IS THIS AN HMO: (YES) _____ (NO) _____

PHONE: _____

COMPANY ADDRESS: _____

POLICY AND GROUP NUMBERS: _____

POLICYHOLDER'S NAME: _____

POLICYHOLDER'S DATE OF BIRTH: _____

POLICYHOLDER'S SOCIAL SECURITY NUMBER: _____

POLICYHOLDER'S EMPLOYER: _____

NAME OF SECONDARY INSURANCE _____

IS THIS AN HMO: (YES) _____ (NO) _____

PHONE: _____

COMPANY ADDRESS: _____

POLICY AND GROUP NUMBERS: _____

POLICYHOLDER'S NAME: _____

POLICYHOLDER'S DATE OF BIRTH: _____

POLICYHOLDER'S SOCIAL SECURITY NUMBER: _____

POLICYHOLDER'S EMPLOYER: _____

BE SURE TO INCLUDE A COPY OF YOUR MEDICAL, DENTAL AND PRESCRIPTION INSURANCE CARDS FRONT AND BACK FOR YOUR CADETS MEDICAL RECORDS.

VALLEY FORGE MILITARY ACADEMY AND COLLEGE HEALTH CENTER
1001 EAGLE ROAD, WAYNE, PA 19087
PHONE 610-989-1517/1518 FAX 610-989-1516

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Understanding Your Health Information

Each time you visit a hospital, clinic, physician, or other health care provider, a record of your visit is made. Typically, this health record contains your medical history, symptoms, examination and test results, diagnosis, treatment, care plan, insurance and billing information. This health information is considered private and protected. This health information, often referred to as your health record, serves as a basis for planning your care and treatment and is a vital means of communication among the many health professionals who contribute to your health care. Your health information is also used by insurance companies and other third-party payers to verify the appropriateness of billed services.

We are required by law to:

- Maintain the privacy of your health information.
- Provide you with an additional current copy of our notice upon request.
- Abide by the terms of our current Notice.

How We Disclose Medical Information about You

- **For Treatment:** We may provide medical information about you to doctors, nurses, the athletic trainers or achievement center counselors involved in your care. We also may disclose information about you to people outside the health center who may be involved in your medical care. This includes but is not limited to physicians, family members, emergency contacts, tactical officers, nurses, technicians, medical students or others that may provide part of your care.
- **For Payment:** We may discuss your health information with your insurer, parent/guardian or specified emergency contact to verify your eligibility for benefits, obtain prior authorization, and to bill for the treatment and services rendered.
- **For Health Care Operations:** We may disclose and use your medical information for practice functions such as reviewing the quality of care delivered, education and planning.
- **Appointment Reminder and Follow Up:** We may use your information to contact you as a reminder that you have an appointment with us or a consultant.
- **Other Health Care Providers:** We may disclose your information to other health care providers when it is necessary for them to treat you, receive payment for services rendered or conduct certain health care operations. This includes, but is not limited to athletic training staff and Achievement Center staff.
- **To Avert a Serious Threat to Health or Safety:** We may disclose medical information about you when necessary to prevent a serious threat to your health and safety or that of another person or the public.
- **Public Health Risk or Activities:** We may disclose medical information about you for Public Health Activities. This may include the prevention or control of a disease or illness, report abuse or neglect, to notify people of recalls and to report reactions to medications or vaccinations.
- **Health Oversight Activities:** We may disclose your information to a health oversight agency that is responsible for monitoring the health care system, government programs and compliance with civil rights laws.
- **Legal Proceedings and Law Enforcement:** We will disclose medical information about you when required to do so by federal, state or local law. We may disclose your information in response to a court order, subpoena or other lawful process.

PARENT/GUARDIAN COPY

Your Rights Regarding Your Health Information

- **Right to Inspect and Copy:** You have the right to inspect and copy medical information that may be used to make decisions about your care. You must submit a written request to the Health Center Director, 1001 Eagle Road, Wayne, Pennsylvania, 19087. We may charge a fee for the copying, mailing or use of other supplies associated with your request. We may deny your request to inspect and copy in certain limited circumstances. You may request that the denial be reviewed. Another licensed health care professional chosen by the Health Center will review your request and denial. We will comply with the outcome of the review.
- **Right to Amend:** You have the right to request that we amend the health information we keep about you in your medical and billing records. Request should be made in writing to the Director of the Health Center. We may deny your request if we believe the information you wish to amend to be accurate, current and complete, if the record was not created by the Health Center or if other special circumstances apply.
- **Right to Accounting of Disclosure:** You have the right to request an accounting of disclosure. We are not required to give you an accounting of information we have used or disclosed for treatment, payment, health care operations or information you authorized us to disclose. Requests should be made in writing to the Health Center.
- **Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request we limit the medical information we disclose to someone involved in your care or the payment of your care. We are not required to agree with your request. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment. Request should be made in writing to the Health Center Director.
- **Right to Request Confidential Communication:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. Request should be made in writing to the Health Center Director.
- **Right to Revoke Your Written Permission (Authorization):** You may change your mind about your authorization or any written permission regarding your Highly Confidential Information by giving or sending a written "revocation statement" to the Privacy Office at the address below. The revocation will not apply to the extent that we have already taken action where we relied on your permission.

Changes to This Notice:

We reserve the right to revise this notice. We reserve the right to make the changed notice effective for the information we already have as well as any information we may receive in the future.

Complaint:

If you believe your privacy rights have been violated, you may file a complaint with the Health Center Director. There will be no retaliation for filing a complaint.

Other Use of Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain a record of the care that we provided to you.

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 1001 EAGLE ROAD, WAYNE, PA 19087
 PHONE 610-989-1517/1518 FAX 610-989-1516

Acknowledgement of Receipt of Notice of Privacy

By signing below, I acknowledge the receipt of the Notice of Privacy Practice of Valley Forge Military Academy and College.

Parent Signature _____ Date _____

Cadet Signature _____ Date _____

Authorization to Disclose Protected Health Information

By my signature I hereby authorize the Valley Forge Military Academy and College Health Center to disclose my cadets health information to persons listed below.

Custodial Parent/Guardian _____

May we leave a message? Yes No

Parent/Guardian _____

May we leave a message? Yes No

Emergency Contact (other than parent) _____

May we leave a message? Yes No

Others: _____

Family Physician/ Pediatrician's Office

Doctors' Name(s) _____

Address _____

Phone _____ Fax _____

Parent's Signature _____ Date _____

Cadet Signature _____ Date _____

Release of Medical Information

I hereby authorize the release of all requested and pertinent past and present medical records to the Health Center at Valley Forge Military Academy and College to assist in the continuity of care.

Parent's Signature _____ Date _____

Cadet Signature _____ Date _____

(RETURN TO THE HEALTH CENTER)

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

CADET 18 YEARS OF AGE AND OLDER

Cadet's Name (Please print): _____

The Valley Forge Military Academy & College is committed to protecting each Cadet's privacy, in regard to certain health information as mandated by state and federal laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and will generally not release a Cadet's Protected Health Information without first obtaining the Cadet's authorization. "Protected Health Information" (PHI) includes information that has been created or received by the Valley Forge Military Academy & College regarding your health. It includes your medical records, current medications/treatment and personal information such as your name and social security number.

Authorization for Use/Disclosure of Information: I voluntarily authorize and direct the Office of Cadet Health Services to use or disclose my Protected Health Information during the term of this Authorization to my parents and/or legal guardian, the Tactical Officer assigned to my Unit and to my faculty advisor.

Purpose: This Authorization is made at my request to assist in my ongoing medical care and to best facilitate my educational experience at the Valley Forge Military Academy & College.

Information to be Disclosed: This authorization permits the Valley Forge Military Academy & College to disclose the following medical records/information:

Those medical records and information concerning any prescribed medication that I am taking while enrolled at the Valley Forge Military Academy & College, as directed by my personal physician.

Term: This Authorization will remain in effect from the date of this Authorization until the date I am discharged from the Valley Forge Military Academy & College.

Right to Revoke: I understand that I may revoke this Authorization for any reason and that such revocation will not affect the commencement, continuation or quality of my treatment as facilitated by the Office of Cadet Health Services or my educational opportunities at the Valley Forge Military Academy & College.

Cadet's Signature

Date

HS11.027

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

**PRIVATE DENTIST REPORT OF
DENTAL EXAMINATION OF A PUPIL OF
SCHOOL AGE**

NAME OF SCHOOL _____ DATE _____ 19__

NAME OF CHILD			AGE	SEX	GRADE	SECTION/ROOM
Last	First	Middle		<input type="checkbox"/> M <input type="checkbox"/> F		

ADDRESS

No. and Street	City or Post Office	Borough or Township	County	State	Zip
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REPORT OF EXAMINATION

	TOOTH CHART																
	RIGHT								LEFT								
UPPER	1	2	3	4 A	5 B	6 C	7 D	8 E	9 F	10 G	11 H	12 I	13 J	14	15	16	Upper
LOWER	22	21	20	19 T	18 B	17 R	16 Q	15 P	14 D	13 N	12 M	11 L	10 K	9	8	7	Lower
UPPER																	Upper
LOWER																	Lower

Is The Child Under Treatment Yes No

Treatment Completed Yes No

Date of Dental Examination

Signature of Dental Examiner

Print Name of Dental Examiner

Address