BEACON COLLEGE

Authorization for Treatment

I hereby grant permission to the staff of Student Services/Health Services of Beacon College to render any first aid/health care or emergency treatment to myself (son/daughter). I also grant permission for the above referenced Beacon College staff to arrange health care, emergency treatment or hospitalization at an accredited hospital or medical, psychological or dental care facility when considered necessary.

Student Signature	**Date**
Parent/Guardian (required if student is under 18)	**Date**

BEACON COLLEGE

Health Insurance and Health Care Expenses

Verification of health insurance must be submitted upon enrollment and annually for all students, please be sure to put the date on the copy (front and back) of your student's insurance card.
All medical expenses incurred by students are the responsibility of the individual student, or parent/guardian if student is a minor. It is required that all students carry health insurance.

When submitting the required forms and documentation to Beacon College personnel, please attach a copy, front and back, of your insurance card.

Please be aware that if you are insured by an HMO (Health Maintenance Organization), you might not be covered for non-emergency services while on campus and outside the plans network. We urge you to contact your plan administrator for details on your coverage. Also, some health plans are PPO's (Preferred Provider Organization) and require that you use "preferred" clinicians for off campus care that you might require while attending Beacon College. Your plan administrator can provide you with a list of the providers for Leesburg, FL and surrounding areas.

Please let us know right away if you have no insurance coverage, we are able to provide you with insurance options through the American College Student Association (ACSA).

INSURANCE INFORMATION

All students are required to have health insurance – complete information below and a copy of the insurance card (front/back) must be on file.

Student's Name: _____

***Insurance Company*:** _____

Policy Number: _____ ***Group Number:*** _____

City/State/Zip: _____ ***Telephone Number:*** _____

Policyholder's Name: _____ ***Employer***: _____

Copy of front & back of the insurance card is required!!

I hereby assign the benefits of my insurance policy to designated health care providers as appropriate. I understand that I am responsible for all charges that are not paid by that policy. I authorize the release of information needed to my insurance company in order to consider payment of my claim for services rendered. I understand that this assignment and authorization will remain in effect indefinitely or until such time that I give written notice to the contrary.

Policyholder signature: _____ ***Date:*** _____

Mandatory Immunization Form

Complete and send this form to the address specified as soon as possible. Completion of this form is necessary to comply with the Florida Statute 1006.69 and the Florida Admin Rule 6C-6.001(5). This form is also available in the Office of Student Services. **Please print clearly in black or blue ink. Please complete this form. DO NOT SIMPLY ATTACH THE STUDENT'S CHILDHOOD IMMUNIZATION FORM. Thank you!**

Name: _____ (Last) _____ (First) _____ (Initial) ❒ Male ❒ Female

Date of Birth: _____ (Month) _____ (Day) _____ (Year)

Term/Year for which you are applying or returning : ❒ Fall ❒ Spring _____ (Year)

A. Immunizations required of ALL students entering Beacon College:

MMR (Measles/Mumps/Rubella)

Dose 1 (MM DD YY) Dose 2 (MM DD YY)

-OR-

Measles (Rubeola)

Dose 1 (MM DD YY) Dose 2 (MM DD YY) OR Titer/Date (MM DD YY)

Copy of lab report must be attached

-AND-

Rubella (German Measles)

Titer/Date (MM DD YY) OR (MM DD YY)

Copy of lab report must be attached

*****Meningitis Vaccine** (MM DD YY)

*****AND Booster IF 1st. dose of Meningitis Vaccine was given before 16 years of age:** (MM DD YY)

For international students ONLY:

TB (Tuberculosis) (MM DD YY)

Hepatitis B (If Positive HepB surface antibody attach copy of lab results)

Dose 1 (MM DD YY) Dose 2 (MM DD YY) Dose 3 (MM DD YY)

Td (Tetanus/Diphtheria) (MM DD YY)

Tdap (Tetanus/Diphtheria/Pertussis) (MM DD YY)

B. Immunizations recommended for good health:

Mumps (MM DD YY)

HPV (MM DD YY)

Polio (last dose) (MM DD YY)

Varicella (Chicken Pox) 2 shots or date of illness

Dose 1 (MM DD YY) Dose 2 (MM DD YY) *OR* Date of Illness (MM DD YY)

Hepatitis A

Dose 1 (MM DD YY) Dose 2 (MM DD YY)

C. An official stamp from a doctor's office, clinic, or health department AND an authorized signature must appear on this form.

_____ Name of Public Health Clinic or Physician (facility stamp)

_____ Physician or Authorized Signature

_____ Date

Send or fax form as soon as possible to:

-OR-

Attention: Debra D. Allen
Beacon College, Student Services
105 East Main St. Leesburg, FL 34748

EFax (800) 313-0339
Phone (352) 638-9701

PLEASE KEEP A COPY FOR YOUR RECORDS

Medical Action Plan & Local Medical Resource List

Merriam-Webster's Desk Dictionary defines transition as "passage from one state or stage to another". So whether you are entering college for the first time or are a transfer or continuing student, you are experiencing important transitions in your life. You are transitioning to a new place, new responsibilities, new challenges.

To get started:

The MAP must be completed by ALL students .

- *If you have chronic medical needs, the MAP will help you be better prepared to take responsibility for your health needs.*

- *Continuity of quality medical care is of primary importance to your success in college. Local Medical Resources are provided for your reference on pages 4-7.* ***Please keep those pages for future reference.***

Now is the time to prepare yourself. Establish a routine that supports your best health. Keep a calendar to manage your responsibilities: going to class, mentoring, keeping appointments, taking medications as prescribed, eating healthy, studying, sleeping, exercising, socializing, etc. Get involved! There are many workshops, student activities, clubs, and organizations to support your personal wellness.

If you have any questions or concerns or need assistance, please contact me.

Sincerely,

Debra D. Allen RN, MSN, FNP
Director of Student Health
Student Services, Beacon College
(352) 638-9701
dallen@beaconcollege.edu

NAME: _____

MEDICATION

Planning for success means making the right choices for your health. Now that you are in college and living on your own, it is important that you plan ahead for success. Properly taking medications can make the critical difference between success and failure. Know the name, purpose, side effects, restrictions, interaction precautions, how to take, and how to order and pay for your medications. Keep a calendar, plan ahead so you don't run out! An interruption in taking medication can sometimes have adverse effects. Take a minute and consider the following questions, answer to the best of your ability.

☐ **(check if applicable) I'm not taking any prescribed medications.**

How will you make sure you take your medication as prescribed?

☐ Take on my own ☐ Take when reminded by a parent
☐ Take with help of a pill organizer ☐Take with Lab/Doctor Assistance
Other_____

How will you make sure you keep a supply of medication to make sure you don't run out?

☐ Local Pharmacy ☐ Mailed from Home ☐ Mailed direct from Pharmacy
☐ Own Transportation to Pharmacy ☐College Transportation to Pharmacy
Other_____

How will you pay for your medication? (Check all that apply, explain if needed)

☐ Parent ☐ Student ☐ Direct through Pharmacy or Insurance

What happens when you don't take your medication? What happens when you do? _____

Medication	How often to Refill?	Next Date to Refill?	Instructions for taking

NAME:

MEDICAL CARE

Plan Ahead! Do your homework now and identify medical care professionals close to Beacon College. Schedule appointments in advance and have records forwarded. If using college provided transportation, reserve your time in advance-remember this is a first come first serve basis. Be sure to notify transportation and the doctor if you need to cancel or reschedule an appointment. You may still need to pay if you fail to keep an appointment or to cancel or reschedule with advance notice. *It is especially important for students with chronic illnesses to establish a relationship with a local physician who can monitor their care.*

Medical Care at Home

Doctor Name	Type of Practice	Scheduled appointments/ frequency	Phone Number

Local Medical Care while at Beacon

Doctor Name	Type of Practice	Scheduled appointments/ frequency	Phone Number

Signature:_____ Date:_____

LOCAL MEDICAL RESOURCE LIST
PLEASE KEEP PAGES 4-7 FOR YOUR RECORDS

This information is provided as an example of medical service practitioners in the Leesburg area. This list does not represent an endorsement or recommendation by the college, its directors, officers or employees, of any particular medical service provider or practitioner. Before seeking medical assistance be sure to check with your insurance company. Students are responsible for arranging their own medical appointments and transportation. Limited transportation is available on a first come basis during weekday business hours and is limited to necessary medically related issues; contact the Transportation Coordinator to schedule transportation. There may be a minimal fee and service may be limited to a 20 mile radius. Students and/or parents are responsible for payment of all medical expenses.

Family Physicians

Physicians' Referral
(352) 323-1000

Leesburg Family Medicine
802 East Dixie Ave., Leesburg, FL 34748
(352) 787-1324

Dr. Rolando Menendez
608-A South 9th St., Leesburg, FL 34748
(352) 365-2221

Leesburg Community Health Center
225 N. 1st Street, Leesburg, FL 34748
(352) 360-0490

Lake County Health Department
14 N. Eustis Street, Eustis, FL 32726
(352) 589-6424

Lakeview Internal Medicine, P.A.
101 S. 11th Street, Suite 4
Leesburg, FL 34748
(352) 460-4004

Psychiatrists

Advanced Behavioral Health Center
Dr. Luis Torres
1799 Salk Ave., Tavares, FL 32778
(352) 742-8300

Dr. Hector Deleon
221 N. Joanna Ave., Tavares, FL 32778
(352) 742-8300

Psychologists

NCS Counseling and Development Center
Dr. Nadine Vaughan
101 East Maud St., Tavares, FL 32778
(352) 253-9348

Central Florida Psychological Consultants
Dr. W. Steven Saunders
1114 W. Dixie Ave., Leesburg, FL 34748
(352) 365-2243

Lake Center of Hope
Dr. Ludy Ungson
33057 Professional Drive, Suite 102
Leesburg, FL 34788
(352) 787-0081

Dr. Patrick Ward
101 E. Maud Street, Tavares, FL 32778
(352) 253-9348

Counselors

Ms. Peggy Keene
301 N. Baker St. Suite 213
Mount Dora, FL 32757
(352) 742-0069

Associates for Counseling Services, P.A.
217 N. 14th Street, Leesburg, FL 34748
(352) 365-1098

LOCAL MEDICAL RESOURCES

Cardiologists

Florida Heart & Vascular Center
511 Medical Plaza Drive #101
Leesburg, FL 34748
(352) 728-6808

Lake Heart & Medical Center
732 N. 3rd St., Leesburg, FL 34748
(352) 728-2532

Neurologists

Lake Neurology Clinic
Dr. Marilyn Patterson
608 S. 9th Street, Leesburg, FL 34748
(352) 360-1122

Neurological Associates of Lake County
601 Medical Plaza Drive, Leesburg, FL 34748
(352) 787-7611

Allergists/Asthma

Dr. Thomas Shen
8245 CR 44 Leg A, Leesburg, FL 34748
(352) 314-2929

Dentists

Main Street Dentists
606 W. Magnolia Street, Leesburg, FL 34748
(352) 787-4800

The Dental Touch
918 East Dixie Ave.
Leesburg, FL 34748
(352)728-8300

Oral Surgeon

Dr. Ed Blanton
2149 US Hwy 441, Leesburg, FL 34748
(352) 728-6600

Central Florida Oral & Maxillofacial Surgery
265 Hatteras Ave., Clermont, FL 34711
(352) 242-5331

Ear, Nose, & Throat

Lake Ear, Nose, Throat & Facial Plastic Surgery Associates
Medical Plaza 901, 601 E. Dixie Ave. Leesburg, FL 34748
(352) 728-2404

Dermatologists

Lake Dermatology
1132 E. North Blvd., Leesburg, FL 34748
(352) 365-6650

Advanced Dermatology
1816 Salk Ave.
Tavares, FL 32778
(352)343-2461

Dr. Michel Snyder
608 S. 9th Street, Leesburg, FL 34748
(352) 787-4532

Chiropractors

Lake Chiropractic Clinic
1235 W. Dixie Ave., Leesburg, FL 34748
(352) 787-2785

Leesburg Chiropractic Center
1107 W. North Blvd. #23, Leesburg, FL 34748
(352) 787-4500

LOCAL MEDICAL RESOURCES

Women's Health

Advanced OB/GYN Associates
1414 West Main St.
Leesburg, FL 34748
(352)728-3898

Leesburg Community Health Center
225 N. 1st Street, Leesburg, FL 34748
(352) 360-0490

Nutritionists

Jeff Whitman
914 N. 14th St., Leesburg, FL 34748
(352) 365-6477

David Frerking
915 E. Alfred Street, Tavares, FL 32778
(352) 343-9275

Wellness

LRMC Wellness Center
700 N. Palmetto St.
Leesburg, FL 34748
(352) 323-5640

Labs

Quest Diagnostics
Patient Service Center
101 South 11th St., Suite 2
Leesburg, FL 34748
(352) 787-5721
Hours: Monday-Friday
7:00 a.m. to 4:00 p.m.

Lab Corp of America
601 E. Dixie Ave. Suite 804
Leesburg, FL 34748
(352) 319-8013
Hours: Monday-Friday
7:00 a.m. to 4:00 p.m.

Hospitals

Leesburg Regional Medical Center
600 East Dixie Drive
Leesburg, FL 34748
(352) 323-5762

Florida Hospital—Waterman
1000 Waterman Way
Tavares, FL 32778
(352) 253-3600

Radiology

Advanced Imaging Center
211 N. First St.
Leesburg, FL 34748
(352)435-0111

Lake Medical Imaging
801 E. Dixie Ave
Leesburg, FL 34748
(352)787-5858

Pharmacies

Burry's Pharmacy
500 Webster St., Leesburg, FL 34748
(352) 787-3787

STARx Pharmacy
802 East Dixie Ave., Leesburg, FL 34748
(352) 323-9555

Publix Pharmacy
Hwy 27 (14th Street), Leesburg, FL 34748
(352) 787-0664

CVS/Pharmacy
1235 N. 14th Street, Leesburg, FL 34748
(352) 787-7800

Walgreens
901 S. 14th Street, Leesburg, FL 34748
(352) 787-3506/Prescriptions

LOCAL MEDICAL RESOURCES

Cont. Pharmacies

McHills Pharmacy
4120 Corley Island Rd.
Leesburg, Florida 34748
(352)460-4057
Dr. Martin Ugwu

Express Pharmacy Leesburg
1450 N. Boulevard East
Leesburg, Florida 34748
(352)460-0542

Walk-In Care Centers

Central Florida Express Care
501 North Blvd.
Leesburg, FL 34748
(352) 431-3743

STARx Urgent Care
802 East Dixie Ave., Leesburg, FL 34748
(352) 323-9555

Express Care of Leesburg
2500 Citrus Blvd.
Leesburg, FL 34748
(352) 728-5335

US Health Works
210 South Lake St Suite 4
Leesburg, FL 34748
(352)787-4977

Lake Regional Urgent Care
8404 U.S. Highway 441
Leesburg, FL 34788
(352)315-8881

Date:_____

Medical History & Emergency Contact Form

Personal Data – please print legibly in blue or black ink.

Name: _____ _____ _____ ❒ Male ❒ Female
Last First Initial

Date of Birth: _____ _____ _____
Month Day Year

Height: _____ Weight: _____

Email: _____

Cell Phone: _____

Will reside in campus housing? ❒ YES ❒ NO
Year/Term: 20____ ❒ Spring ❒ Fall _____

Emergency Contact: _____

Phone 1: _____
Phone 2: _____

Personal Medical History – please print legibly in blue or black ink.

Do you have any allergies? ❒ Yes ❒ No If yes, please specify. Include medications, insect bites, environmental factors and food allergies.

Do you smoke? ❒ Yes ❒ No Do you use other tobacco products? ❒ Yes ❒ No

Do you consume alcohol? ❒ Yes ❒ No

Please indicate below if you are being treated or have been treated in the past for any of the following and indicate the year.

	YEAR		YEAR
❒ ADD/ADHD		❒ Epilepsy, Seizures **(if yes read Beacon College Seizure Protocol & complete Seizure Action Plan)**	**Date of Diagnosis/Date of last seizure** /
❒ Alcohol/Drug Dependency		❒ Head Injury	
❒ Anemia, Blood Disease		❒ Heart Murmur/Disease	
❒ Anxiety/Depression		❒ Hepatitis	
❒ Arthritis, Joint Disease, Bone Disease		❒ High Blood Pressure	
❒ Asperger's Disorder		❒ Hypoglycemia (low blood sugar)	
❒ Asthma		❒ Lyme Disease	
❒ Bipolar Disorder		❒ Malaria	
❒ Blood Clot/Phlebitis		❒ Migraines	
❒ Cancer		❒ Rheumatic Fever	
❒ Chicken Pox		❒ Schizophrenia	
❒ Diabetes (indicate type)		❒ Thyroid Disease	
❒ Digestive Disorder		❒ Tuberculosis	

Personal Physician: _____
Name Address Phone

Are you currently under the care of any clinical practitioner for any other medical conditions? ❒ Yes ❒ No

Medications (include birth control, vitamins, herbs and dosage, times/day, a.m./p.m., etc.): _____

List operations and/or hospitalizations (include reason and year): _____

Mental Health History: Please answer all questions

Have your academic and/or work activities ever been interrupted because of mental health or emotional problems?
Please explain: _____ ❒ No ❒ Yes

Have you ever been treated with any medication for psychiatric reasons?
Please explain: _____ ❒ No ❒ Yes

Have you ever been hospitalized for mental or emotional problems?
Please explain: _____ ❒ No ❒ Yes

Signature: _____ Date: _____

Physical Examination
TO BE COMPLETED BY HEALTH CARE PROVIDER

TO THE EXAMINER: Please review the student's history and complete the following Physical Examination form. Please comment on all positive findings and be sure all information is complete.

Name: _____ Sex: □ Male □ Female Date of Birth: ___/___/___

Blood Pressure: _____ Pulse: _____ Weight: _____ Height: _____

Visual Acuity: OD 20/_____ OS 20/_____ Corrective Lenses: _____

ANY ABNORMALITIES OF:

	Y	***N***	***Explain***
Skin			
Head, Eyes, Ears, Nose, Throat			
Neck, Thyroid			
Lungs			
Heart			
Abdomen			
Genitals			
Hernia			
Extremities/Joints			
Neurological			
Mental Status			

List Current Medications: □ N/A _____
_____

List Allergies (Medications/Environmental/Food): _____

Surgical History: _____

Mental Health History: _____

Full unlimited athletic participation: □Yes □No Explain: _____

Date _____ Medical Providers Signature/Stamp:
_____

TUBERCULOSIS RISK QUESTIONNAIRE

Student Name_____ **Date of Birth** _____
Last First MI

	YES	NO
1. To the best of your knowledge have you ever had close contact with anyone who was sick with tuberculosis (TB)?	☐	☐
2. Were you born in one of the countries listed below?	☐	☐
3. Have you traveled or lived for more than one month in one or more of the countries listed below?	☐	☐

COUNTRIES WITH HIGH RATES OF TUBERCULOSIS (TB)*

* World Health Organization. TB burden estimates & Global TB report 2012.

Afghanistan	Congo	Kazakhstan	Niue	Thailand
Algeria	Côte d'Ivoire	Kenya	Northern Mariana Islands	Timor-Leste
Angola	Democratic	Kiribati	Pakistan	Togo
Armenia	Democratic	Lao People's	Palau	Turkmenistan
Azerbaijan	Djibouti	Latvia	Panama	Tuvalu
Bangladesh	Dominican	Lesotho	Papua New Guinea	Uganda
Belarus	Ecuador	Liberia	Peru	Ukraine
Belize	Equatorial Guinea	Libyan	Philippines	United Republic of
Benin	Eritrea	Lithuania	Republic of Korea	Uzbekistan
Bhutan	Ethiopia	Madagascar	Republic of Moldova	Vanuatu
Bolivia (Plurinational	Gabon	Malawi	Romania	Viet Nam
Bosnia and Herzegovina	Gambia	Malaysia	Russian Federation	Yemen
Botswana	Georgia	Mali	Rwanda	Zambia
Brazil	Ghana	Marshall Islands	Sao Tome and Principe	Zimbabwe
Brunei Darussalam	Greenland	Mauritania	Senegal	Thailand
Burkina Faso	Guam	Micronesia	Sierra Leone	Timor-Leste
Burundi	Guatemala	Mongolia	Solomon Islands	Togo
Cambodia	Guinea	Morocco	Somalia	Turkmenistan
Cameroon	Guinea-Bissau	Mozambique	South Africa	Tuvalu
Cape Verde	Guyana	Myanmar	South Sudan	Uganda
Central African Republic	Haiti	Namibia	Sri Lanka	Ukraine
Chad	Honduras	Nepal	Sudan	
China	India	Nicaragua	Suriname	
China, Hong Kong SAR	Indonesia	Niger	Swaziland	

- If you answered **YES** to <u>any</u> of the above questions, you are considered **"high-risk"** and are required to submit documentation of recent PPD testing on the **Immunization** form. PPD testing should be within the last 12 months.

If the Mantoux PPD test is positive <u>(≥ 10mm)</u>, you must submit a copy of a chest x- ray report in English dated within the last 6 months.

Please note: If you have had a positive tuberculin skin test in the past, you do not need another test. Please note prior treatment completed.

Name:_____ **Date:**_____