MOODY BIBLE INSTITUTE
HEALTH SERVICE DEPARTMENT

Welcome to Moody!

Congratulations on your acceptance to the Moody Bible Institute! Health Service is available to assist you with health concerns you may have as a student here at MBI. Our office hours are listed below.

All students enrolling at MBI are required to have all Health Forms submitted to MBI Health Service **by July 15th for Fall and January 1st for Spring Enrollment.** Since some Health Care Providers make appointments up to six weeks in advance, you will need to make your appointment as soon as possible. Please read the forms in their entirety before you call your physician's office for an appointment. Please ensure that all forms include your name and provider's signature, when required.

Please refer to the checklist for further instructions for completing the required health forms. If you have questions about these requirements or need to obtain additional forms, you may contact us at (312)-329-4417. **We only accept documentation on our MBI Health Forms.**

Students who have not completed their health records prior to arriving on campus will be required to complete them either in Health Service or at a local Health Clinic, at the student's own expense. **If you were previously a student at MBI please contact Health Service in order to determine what needs to be completed in order to update your Health Records.**

Health Service Staff is not able to answer questions about Student Health Insurance. Please contact the Student Health Insurance Coordinator at Moody Central at (312)-329-2020.

Please note that Health Service **will not disclose** your protected health information to any other Moody Department unless you sign a Medical Record Release Form.

Thank you for your prompt attention to the above matters to ensure the smoothest possible transition into your Moody Bible Institute student experience!

Sincerely,

Ann Meyer

Miss Ann Meyer, RN-BC, BSN, MHA
Administrator of Health Service

Phone: (312)-329-4417
Fax: (312)-329-4419

820 N LaSalle Blvd
Health Service Department

Chicago, IL 60610

Monday-Friday
9:30am-12:00pm

1:00pm-4:00pm

REQUIRED FOR CHICAGO CAMPUS
CHECKLIST FOR COMPLETION

Please read the directions in their entirety before completing the forms.
Questions about completion of these forms should be directed to the Health Service Department (312) 329-4417
prior to seeing your Health Care Provider.

I. Documentation Requirements

☐ We accept documentation on **MBI forms only.**

☐ Please **DO NOT** staple or paperclip your forms!

☐ Grad Students only need to complete Parts I-V (Part VI is only required for Undergrad Students).

☐ Please fill out the top portion of each form prior to seeing your health care provider. **Please write with a ball point pen.**

☐ Your Health Care Provider must sign each form. Please **double check** you have all required signatures before leaving the office.

☐ All requests for an extension to complete the required health forms must be submitted in writing and received in the Health Service office prior to the deadline of **July 15th for Fall and January 1st for Spring.**

☐ Please **make a copy** of your Health Records for yourself before you mail them to us. **We are not responsible for records that are lost in the mail.**

II. Immunizations

☐ Two doses of vaccines containing Measles, Mumps and Rubella are required. Please make sure your first MMR immunization was given on or after your first birthday and the second MMR Immunization was given at least 28 days after the first MMR.

☐ Three doses of vaccines containing Tetanus, Diphtheria and Pertussis are required for all incoming students. The last TDAP vaccine must have been administered within the last 10 years.

☐ One dose of the Meningococcal Conjugate Vaccine is required for all incoming students 21 years or younger. The first must be given on or after the age of 16 or an additional dose is required. **Menomune and Meningitis B do not meet this requirement.**

☐ All vaccines must be authenticated with a signature from a Health Care Provider.

III. Tuberculosis Screening

☐ **Tuberculosis Screening is required for all students. It must be completed less than 1 year before the start of classes.**

☐ You may substitute a QuantiFERON® Gold TB Test in place of the Mantoux TB Skin Test. A copy of the lab report must be attached to your health forms.

☐ If you have received a BCG Vaccine the QuantiFERON® Gold TB Test is **required.**

☐ If you have history of a positive TB Skin Test, you must provide documentation of the positive TB Skin Test, and show proof of completing 9 months of INH.

☐ All international students must receive their TB Screening in Health Service two weeks after arriving in the United States.

☐ If you plan to travel outside the United States before coming to campus please wait until two weeks after you return to complete your TB Screening.

III. Additional Information

☐ Any student who takes any injections in their room must come to Health Service immediately upon arrival to campus to arrange for proper disposal of sharps. These items cannot be disposed of in normal trash containers.

☐ Allergy Shots cannot be given on campus. Please Contact our office to make arrangements to receive them off campus.

☐ **Failure to complete the Health Forms will result in a hold on your registration for the next semester. Students who have not completed their health records prior to arriving on campus will be required to complete them either in Health Service or at a local Health Clinic, at the student's own expense.**

Health Records are due in Health Service no later than July 15th for Fall & January 1st for Spring

REQUIRED FOR CHICAGO CAMPUS
IMMUNIZATION RECORD

PART I – To be Completed By Student

Last Name	First	Middle	Student ID	Student Phone ( )

Home Address	Date of Enrollment ☐ Undergraduate ☐ Fall ☐ Spring Year_____ ☐ Graduate
City/State/Country/Zip or Postal Code	E-mail Address

Date of Birth (mm/dd/yyyy)	Age	Gender ☐ Male ☐ Female	Citizenship ☐ U.S. ☐ Other (specify)	F-1 International Student Visa ☐ Yes ☐ No

I hereby Authorize Moody Bible Institute Health Service to make this Immunization Record available to the Illinois Department of Public Health or its designated representative.

Student Signature	Date of Signature
Parent/Guardian Signature (if under 18)	Date of Signature

PART II – To be Completed by a Health Care Provider*

REQUIRED IMMUNIZATIONS (dates required)

Licensed Provider: Complete Immunization documentation or attach signed physician/school immunizations.

■ **MEASLES-MUMPS-RUBELLA** – 2 shots against measles, mumps, and rubella (exempt if born before 1/1/57)

MMR 2 doses at least 28 days apart AND after 12 months of age AND both given after 12/31/1967	1 mm/dd/yy 2 mm/dd/yy	***OR***	**MEASLES (Rubeola)** 2 doses at least 28 days apart AND after 12 months of age AND both given after 12/31/1967	1 mm/dd/yy 2 mm/dd/yy
Positive serum titers are also acceptable proof of immunity against measles, mumps and rubella. ☐ Required lab report attached.			**MUMPS** 2 doses at least 28 days apart AND after 12 months of age.	1 mm/dd/yy 2 mm/dd/yy
Documentation of dates of disease **IS NOT** acceptable evidence of immunity against measles, mumps or rubella.			**RUBELLA** 2 doses at least 28 days apart AND after 12 months of age.	1 mm/dd/yy 2 mm/dd/yy

■ **TETANUS-DIPHTHERIA-PERTUSSIS (DPT, DTP, DTaP, TD, Tdap)**
3 or more doses of diphtheria, tetanus vaccine. One dose MUST be a Tdap.
*The most recent vaccine must have been administered within the last 10 years.

1 *after 2 months of age*	2 *A minimum of 28 days after the first*	3 **REQUIRED Within 10 Years**
☐ DTP / DTaP ☐ Tdap ☐ TD _____/_____/_____	☐ DTP / DTaP ☐ Tdap ☐ TD _____/_____/_____	☐ **Tdap** _____/_____/_____
mm/dd/yy	**mm/dd/yy**	**mm/dd/yy**

■ **MENINGOCOCCAL CONJUGATE VACCINE -** The Meningococcal Conjugate Vaccine **is REQUIRED after the age of 16** for all students 21 and younger. **Menomune and Meningitis B do not meet this requirement.**

1 mm/dd/yy
2 mm/dd/yy

RECOMMENDED IMMUNIZATIONS (complete if received)

☐ HEPATITIS A	1 mm/dd/yy	2 mm/dd/yy	
☐ HEPATITIS B	1 mm/dd/yy	2 mm/dd/yy	3 mm/dd/yy
☐ VARICELLA	1 mm/dd/yy	2 mm/dd/yy	☐ Had Varicella Disease (Chickenpox)
☐ OTHER (Specify)	1 mm/dd/yy	2 mm/dd/yy	3 mm/dd/yy

Required Healthcare Provider Verification*

Provider Name (print or stamp)	Title	Signature	Date

Address	Phone

*A "Health Care Provider" is defined as an M.D., D.O. or R.N, who is not a family member. It may also be an L.P.N or Medical Assistant who has had specific training in administering and reading Mantoux TB skin tests and Vaccines and who is directly supervised by an M.D. or R.N.

Mail to: 820 N. LaSalle Blvd. Attn. Health Service Chicago, IL 60610 Fax: (312) 329-4419

REQUIRED FOR ALL CHICAGO CAMPUS
TUBERCULOSIS SCREENING

PART III – To be Completed by the Student

Last Name	First Name	Middle	Student ID	Date of Birth (mm/dd/yyy)

	If you answer YES to any of the questions, please describe	Answer	Explanation
1	Have you ever been told that you have an immune disorder or illness?	☐ Yes ☐ No	If you leave the US after your skin test, it will have to be done again.
If	Have you received a live vaccine in the past 4 weeks? (i.e. measles, mumps, rubella, chickenpox, or shingles).	☐ Yes ☐ No	
3	Have you been outside the United States in the past 2 weeks? (**If YES**, please wait 2 weeks after your return to the US to complete the test).	☐ Yes ☐ No	Date Returned
4	Have you ever had a positive TB Skin Test? When?	☐ Yes ☐ No	
5	Have you ever been told by a healthcare provider that you had active TB?	☐ Yes ☐ No	
6	Have you ever taken medications for TB? Which Medications? When?	☐ Yes ☐ No	If yes, provide documentation
7	Have you ever had a BCG Vaccine for TB? (BCG does not exempt you from this requirement). **If Yes, complete option 2 below**.	☐ Yes ☐ No	**International students must complete screening in the USA or at Health Service**
8	Were you born outside the United States? (If yes, Where?)	☐ Yes ☐ No	
9	Are you an International Student? (If yes, please list your home country).	☐ Yes ☐ No	

If you answered "YES" to any of these questions STOP, Do not proceed to Part IV

TB Screening (either TB Skin Test or QuantiFERON blood test) is REQUIRED for ALL Students

PART IV – To be Completed by a Health care Provider* REQUIRED

Screening may include placement of Mantoux Skin Test or IGRA Blood Test (i.e. QuantiFERON Gold, T-Spot, Etc.) If you are unsure how to proceed please refer the student to MBI Health Service for their Required TB

Option #1 Mantoux Skin Test (no history of BCG)

PLACEMENT

An Intradermal TB skin test (Mantoux Method) was placed on

☐ Left Forearm ☐ Right Forearm

Date mm/dd/yy	Time

READING

Measured result in millimeters of induration. If no induration state "none" or "0mm" Do not write "neg" or "negative"	**RESULT**
Date mm/dd/yy	Time

Option #2 IGRA Blood Test (history of BCG)

Required for patients with history of BCG Vaccine

Type of IGRA Labs Drawn (Specify)

Date mm/dd/yy

RESULT

☐ Positive

☐ Negative

Please Attach All Documentation

Including lab and chest x-ray reports if completed

Health Care Provider Name	Title	Address

Signature	Date (mm/dd/yy)	Phone ( )	Fax ( )

*A "Health Care Provider" is defined as an M.D., D.O. or R.N, who is not a family member. It may also be an L.P.N or Medical Assistant who has had specific training in administering and reading Mantoux TB skin tests and Vaccines and who is directly supervised by an M.D. or R.N.

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Attn. Health Service
Chicago, IL 60610
Fax: (312) 329-4419

REQUIRED FOR CHICAGO CAMPUS
CONFIDENTIAL HEALTH HISTORY AND PHYSICAL EXAM

PART V – To be Completed By Student

Last Name	First Name	Middle	Student ID	Date of Birth (mm/dd/yyy)

Please check all conditions you had or currently have and explain details in the box provided.

☐ Acne	☐ Diabetes	☐ Jaundice
☐ ADD/ADHD	☐ Dizziness	☐ Joint Pain
☐ AIDS/HIV	☐ Drug Addiction	☐ Kidney Disease
☐ Alcoholism	☐ Eating Disorder	☐ Mono
☐ Anemia	☐ Epilepsy	☐ Night Sweats
☐ Anxiety	☐ Eye Problems	☐ Pneumonia
☐ Arthritis	☐ Fainting	☐ Polio
☐ Asthma	☐ Frequent Headaches	☐ Rheumatic Fever
☐ Back Problems	☐ Frequent Indigestion	☐ Shortness of Breath
☐ Bladder Infections	☐ GERD	☐ Tuberculosis
☐ Bleeding Disorder	☐ Hearing Loss	☐ Thyroid Disorder
☐ Cancer	☐ Heart Problems	☐ Ulcers
☐ Chest Pain	☐ Hepatitis B	☐ Other (Specify)
☐ Chronic Cough	☐ Hernia	
☐ Concussion	☐ Hypertension	
☐ Depression	☐ Insomnia	

Please list the following:
Select "None" if Not Applicable

Explanation (Name of Condition and Treatment Information) ☐ None

Allergies (Please List Below)

☐ Epi-Pen (Expiration Date) __/__/____ ☐ None

Surgeries (Operations) ☐ None

Routine Medications and Supplements/Herbal Remedies ☐ None

Permanent Disabilities ☐ None

PART VI – To be Completed by a Physician*

REQUIRED FOR UNDERGRAD STUDENTS ONLY

Height	Weight	Appropriate Weight for Age/Height? ☐ Yes ☐ No	BMI	BP	Pulse	Blood Type (optional)

Physical Exam	Normal	Abnormal	Describe Abnormalities, Surgeries, Significant History
Skin			
Eyes, Ears, Nose, Sinuses			
Mouth, Throat, Tonsils			
Cardiovascular			
Respiratory			
Gastrointestinal			
Genito-Urinary			
Endocrine			
Musculo-Skeletal System			
Nervous System			
Psychiatric			
Menstrual History (Female Only)			☐ Oral Contraceptives (Specify)

Notes	Medications	Allergies

ON THE BASIS OF THIS EXAM I APPROVE THIS STUDENT'S PARTICIPATION IN
☐ Intensive Study ☐ Physical Education Classes ☐ Neither (Please Attach Explanation)

If any current condition or prescribed medication requires monitoring by lab tests please send a copy of the most recent lab work

Health Care Provider name	Title	Date	
Signature		Phone ( )	Fax ( )

*May also be completed by a Nurse Practitioner or Physician's Assistant

Mail to: 820 N. LaSalle Blvd.
Attn. Health Service
Chicago, IL 60610
Fax: (312) 329-4419

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MOODY BIBLE INSTITUTE
NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act ("HIPAA")

This notice applies to the Moody Bible Institute Health Service.

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

I, _____, request **Moody Bible Institute** to keep communications regarding my protected health information confidential. To accomplish this you can contact me by phone at

Print Name

Home/Cell: _____

Work: _____

Email: _____

Other Requests for confidential communications:
(If you are 18 or older we cannot communicate with your family, including your parents without your written consent, so please be very specific. Include names and phone numbers of people we can communicate with regarding your protected health information.)

_____
_____
_____
_____

Acknowledgment of Receipt of Notice of Privacy Practices

I,_____, acknowledge that I have received a copy of the
Print Name

Moody Bible Institute Notice of Privacy Practices.

Signature **MBI ID#** **Date**

Office Use Only

We attempted to obtain written acknowledgment of receipt of privacy practices, but acknowledgment could not be obtained because:

- ❑ **Individual refused to sign.**
- ❑ **Communication barrier prohibited obtaining the acknowledgment.**
- ❑ **An emergency situation prohibited obtaining the acknowledgment.**
- ❑ **Other: (Please Specify)** _____
- ❑ **Comments:** _____

THIS NOTICE BECAME EFFECTIVE ON JANUARY 1, 2010.

MOODY BIBLE INSTITUTE
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. PLEASE REVIEW IT CAREFULLY.

This notice, which became effective on January 1, 2010 applies to the Moody Bible Institute Health Service (MBI Health Service).

UNDERSTANDING YOUR HEALTH INFORMATION AND MEDICAL RECORD: This notice of Privacy Practices describes the privacy practices of MBI Health Service. MBI Health Service wants you to know that nothing is more central to our operations than maintaining the privacy of your Protected Health Information ("PHI"). PHI is information about you, including basic information that may identify you and relates to your past, present, or future health conditions, symptoms, exams, test results, diagnoses, treatment given, and a plan for future care or treatment. This medical information is used to plan your care and treatment and be a source of your health information.

YOUR HEALTH INFORMATION RIGHTS: Your medical record which contains your PHI is the property of MBI Health Service. Federal and Illinois laws provide you with the following rights regarding your PHI that is contained in the medical record that MBI Health Service keeps about you. These rights include the right to:

- obtain a copy of this Notice of Privacy Practices.
- request certain restrictions on the uses and disclosures of your PHI.
- request a copy of your health record.
- request an amendment to your health record if you believe it contains an error.
- obtain a list of people and companies to which MBI Health Service has released your health information.
- request that we communicate with you about your healthcare at a confidential phone number or address.
- revoke your written consent or authorization to use or disclose your health information except when the use or disclosure has already happened.
- receive notification of a breach of privacy or security of your PHI.
- provide access your electronic health record if your PHI is maintained electronically.
- report a breach relating to the privacy or security of your PHI.

Federal and Illinois law also provide you with the right to be informed about and give written authorization before any health information, including highly confidential information, is disclosed, unless such a disclosure is required by law. Examples of highly confidential information are mental health treatment, substance abuse or referral, developmental disability services, HIV/AIDS testing and treatment, venereal disease treatment, sexual assault treatment and testing and genetic testing information and results.

MBI HEALTH SERVICE'S RESPONSIBILITIES:

- Maintain the privacy of you health information as required by law.
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Do what is required by the Federal and State law in effect at the time MBI Health Service discloses your health information.
- Notify you if we are unable to agree to your requested restriction on disclosure of your health information.

- Agree to reasonable requests to communicate your health information by an alternative method or to an alternative location.

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION: MBI Health Service will use your health information contained within the Health Service medical record to give you treatment, for you to receive reimbursement for your treatment, and to operate our health care businesses. We will not disclose your PHI to any health plan for payment or operations if you have paid out of pocket and in full for the services rendered.

EXAMPLES OF HOW YOUR HEALTH INFORMATION WILL BE USED OR DISCLOSED FOR TREATMENT, REIMBURSEMENT, AND OPERATIONS:

We will use your health information for treatment.

For example: Your physician, nurse and other member of your healthcare team will collect information about you in your medical record. We may disclose information to another health care provider who will be assuming your care, for immediate continuity of care. This health information will be used to choose the treatment they believe is best for you; members of the team will document in your medical record the actions they took and their observations of you. Your physician will then know how you are responding to the chosen treatment.

We will use your health information for you to receive reimbursement.

For example: We will send an itemized receipt that includes some of your health information to you to submit to the person responsible for the bill and to your third party payer (such as your Health Insurance Company or Medicare). In some instances, you may need to send a copy of part or all of your medical record to your third party payer. This information will be disclosed only upon completion of our request for medical records release form.

We will use your health information for our routine operations.

For example: Physicians, nurses, and other professionals will use your health information to review the treatment you received and its outcomes. They also may compare your treatment and outcomes to those of other patients like you. We compare cases to help us learn how to improve the quality and effectiveness of our health care services.

OTHER USES OR DISCLOSURES OF YOUR HEALTH INFORMATION

MBI Health Service is enrolled in the Illinois Department of Public Health I-CARE (Illinois Comprehensive Automated Immunization Registry Exchange) program. We will use this program to enter and retrieve Immunizations.

Upon receipt of your written authorization to use and/or disclose your health information. We will use and/or disclose your health information to those persons or companies for which you give us your written authorization or permission to do so. If you authorize us to use or disclose your information, you must complete our request for medical records release form. A person who can verify your identity must witness and co-sign a request for medical records release form. You may revoke your authorization in writing at any time except to the extent that we have already used or disclosed your health information as you previously authorized. If your health information includes highly confidential information, we will only use and disclose such information, unless a disclosure is allowed or required by federal or Illinois law, after you have given written authorization to disclose your highly confidential information on our request for medical records release form.

MOODY BIBLE INSTITUTE
NOTICE OF PRIVACY PRACTICES

MBI Health Service may without your written authorization release your health information for the purposes described below.

Other Requests for Confidential Communications

You or your legal representative must tell MBI Health Service which of your relatives or other person(s) may receive information about you. After learning who these persons are, we may, in our best judgment, use and disclose your health information, except for your highly confidential information, to notify these persons of what they need to know to care for you. In an emergency or other situation where you are not able to identify your chosen person(s) to receive communications about you, we may exercise our professional judgment to determine whether such disclosure is in your best interest, who is the appropriate person(s) and what health information is relevant to their involvement with your health care.

Other Communication with You

We may contact you to remind you of appointments or to follow up on the services you received. We may leave messages about appointments or other reminders on your telephone or with the person who answers the phone, or send notices via email or the campus post office.

Business Associates

We provide some services through other persons or companies that need access to your health information to carry out these services. The law refers to these persons or companies as our Business Associates. We may disclose, as allowed by law, your health information to our Business Associates so that they can do the job we have contracted with them to do. We require that our Business Associates use appropriate safeguards to ensure the privacy of your health information. These Business Associates are also governed by Federal law relating to maintenance of your PHI in a confidential manner.

Health Oversight Activities and Specialized Government Functions

We may disclose your health information to an agency that oversees health care systems and ensures compliance with the rules of government health programs such as Medicare, Medicaid, or All Kids, and under certain circumstances to the U. S. Military or the U. S. Department of State.

Law Enforcement Officials, Medical Examiners, Coroners, and Court or Administrative Orders

We may disclose your health information to the police, other law enforcement officials, medical examiners and coroners, and to the courts or administrative proceedings as allowed or required by law, or required by a court order or other legal process.

Funeral Directors and Organ, Eye, and Tissue Organizations

We may disclose your health information to funeral directors as necessary to carry out their duties and as allowed by law; or to organ, eye, and tissue organizations that facilitate organ, eye, or tissue procurement, banking, or transplantation.

Public Health Activities

We may report your identity and other health information to any one of the following: public health authorities for the purpose of controlling disease, injury or disability; to the U.S. Food and Drug Administration for regulating certain products or activities; to government authorities about suspected or known child abuse or neglect, elder abuse and neglect, or domestic violence; to a person exposed to a contagious disease or has risk of contracting or spreading a disease; to your employer and government agencies as required by federal and state laws regarding work-related illness or injury; to prevent or lessen a serious or imminent threat to a person's or public's health or safety; or, to a public or private entity that is authorized to assist in disaster relief efforts.

Research
We may use or disclose your health information to identify you as a potential candidate for a research study that has been approved by an Institutional Review Board or for governmental research studies in which your identifiable information will not be released.

Marketing
MBI Health Service will not use or disclose your health information without your written consent for marketing purposes.

Workers Compensation
We may disclose your health information as allowed or required by Federal and Illinois law relating to workers' compensation or to other similar programs.

Other Uses of Your Information
MBI Health Service may provide you with face-to-face or other communication about products or services related to your treatment, case management, care coordination, alternative treatments, therapies, health care providers, or care settings.

RIGHT TO FILE A COMPLAINT

If you would like to report a privacy problem please contact:

Benefits Manager, Human Resources
Moody Bible Institute
820 N. LaSalle Blvd.
Chicago, IL 60610
(312) 329-4297

If you would like further clarification or additional information, please contact:

Health Service, Moody Bible Institute
820 N. LaSalle Blvd.
Chicago, IL 60610
(312) 329-4417

If you believe your privacy rights have been violated, you may file a complaint with Moody Bible Institute, Director of the Office of Civil Rights (OCR), or the U. S. Secretary of Health and Human Services (HHS). We will not retaliate against you if you file a complaint with us, the OCR, or with the HHS.

Disclaimer:
We reserve the right to change our privacy practices and to use a new Notice of Privacy Practices. If MBI Health Service changes its practices, a new Notice of Privacy Practices will be available upon your request, by mail or in person at MBI Health Service. This Notice of Privacy Practices has been adopted as the only approved Notice for use throughout MBI Health Service. Any changes are unauthorized and invalid.

THIS NOTICE BECAME EFFECTIVE ON JANUARY 1, 2010.