Please return the enclosed required health forms to

Wittenberg University Health and Counseling Center
Greetings from the Health and Counseling Center and Sports Medicine

Dear Students and Parents,

We welcome you to Wittenberg. In this Health Information packet you will find a checklist that will help direct your efforts toward completing all the necessary physical exam, insurance and immunization forms that we need here at the Health and Counseling Center and the Sports Medicine Department. This information is confidential and protected by the HIPAA laws. It is most helpful if the information is specific and complete regarding any of the student’s medical conditions. Please be sure to return them before August 1.

The staff at the Health and Counseling Center provides primary health care to students on campus. The Sports Medicine Department staff provides athletic team related injury care and rehabilitation.

Our goal is to keep the student healthy and prepare him/her to be an advocate for their own health. Our dedicated staff at both locations are very experienced working with college students and love caring for them and teaching them.

Many students come to campus never having had to get a prescription filled on their own, figure out an appropriate dose of Tylenol or check their temperature with a thermometer. Parents, take the opportunity before coming to campus to discuss simple medical issues as they pertain to your student so as to prepare them for campus life. A simple medical kit is usually helpful. Some things to include would be: thermometer, cough syrup, nasal decongestant, acetaminophen and/or ibuprofen, bandaids, ace bandage and throat lozenges. We have all of these things available to your student in the Health Center as well, but often it is more convenient for them if they have it in their room to at least begin their care until they can come in to see us.

Again, welcome and we hope we can be helpful during your stay at Wittenberg.

Shirelle Applin, M.D.

Medical Director
Health and Counseling Center

Ellen Crosbie, A.T., C/L

Head Athletic Trainer
Check List

**The Forms**

Demographic Information / Emergency Contact Information .................................................... 1

Medical History (must be signed by medical provider). ................................................................. 2

Physical Exam (must be completed by medical provider). ............................................................ 3

Certificate of Immunization (must be completed by medical provider) ...................................... 4

Insurance Information / Consent Form ....................................................................................... 5

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Guide to Health and Wellness Center Sports Medicine

Health Care Contact Information

**Mail Health Forms:**

Athletes – do not bring health forms to first day of camp.

Mail health forms to the address on the following page.
Checklist Required for Health Forms

Questions?
Call (937) 327-7811 or e-mail studenthealth@wittenberg.edu (e-mail preferred)

Return to:
Wittenberg University Health Center
Wittenberg University
P.O. Box 720

Deadline: August 1

This checklist is meant to help you complete your health forms in a timely manner. Please mail all completed health forms back to us together at your earliest convenience. Please do not hesitate to call the Health Center at (937) 327-7811 or e-mail us at studenthealth@wittenberg.edu if you need assistance with any Wittenberg University Student Health Form. For your convenience, the forms may be downloaded from our Web site at http://www.wittenberg.edu/administration/health_wellness/forms.

Incomplete information or invalid dates will prevent you from registering for future semesters and a HOLD will be placed on your account.

☐ 1. Complete all six pages of the Student Health Form and return all forms by **August 1**.

☐ 2. If you are under the age of 18, your parent or guardian must sign page 5 and page 6.


☐ 4. You must have a PPD (TB) skin test within the last year. You must have the DATE given and more importantly the RESULTS. If no results it will be considered invalid and the test may have to be repeated. If you have a positive TB skin test, additional testing may be requested.

☐ 5. Copy both sides of your insurance card and attach it to page 5.

☐ 6. Please mail all health forms to address above. Athletes, mail your health forms to address above. **Do not bring** health forms to first day of camp.
Wittenberg University Student Health Form

The information you provide on this form is strictly for the use of the Health and Counseling Center and the Sports Medicine Department and will not be released to anyone without your knowledge and consent. All students must complete these forms. Have the physical exam and certificate of immunization signed by a medical provider (M.D., D.O., N.P., or P.A.).

Date __________________________
Anticipated college graduation year _________

Demographic Information

Name _____________________________________________

Last Name ___________________________ First Name ___________________________ Middle Name ___________________________

Address _____________________________________________

Street Address or P.O. Box ___________________________ City ___________________________ State ___________________________ Zip ___________________________

Phone (_________) ___________________________ Cell Phone (_________) ___________________________

Social Security Number _____________________________

Date of birth ___________________________ Place of birth _____________________________________________

Month ___________________________ Day ___________________________ Year ___________________________

Sports you plan to participate in while at Wittenberg ___________________________

Fall __________ Winter __________ Spring __________

Known Allergies: _____________________________________________

Emergency Contact Information

Personal physician _____________________________________________ Phone ___________________________

Physician’s Address _____________________________________________

Father/Guardian _____________________________________________ Mother/Guardian _____________________________________________

Employer _____________________________________________ Employer _____________________________________________

Work Telephone (_________) ___________________________ Work Telephone (_________) ___________________________

If different from above: ___________________________

Home Address _____________________________________________

City/State/ZIP _____________________________________________

Home Phone (_________) ___________________________ Home Phone (_________) ___________________________

Cell Phone (_________) ___________________________

…………………………………………………………………………………………………………………………

Alternate Contact _____________________________________________ Relationship ___________________________

Home Phone (_________) ___________________________

…………………………………………………………………………………………………………………………

Please make a copy of all forms for your personal record.
Wittenberg University Student Health Form

Medical History

Allergies
Type (food, medication, other)
1. ____________________________
2. ____________________________

Current Medications
Name of medication Dosage Reason for medication
1. ____________________________ ____________________________ ____________________________
2. ____________________________ ____________________________ ____________________________
3. ____________________________ ____________________________ ____________________________

Hospitalization and/or Surgery
Date Description
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Medical Illnesses or Problems
Have you ever had or do you now have any of the following?

<table>
<thead>
<tr>
<th>Medical Illnesses or Problems</th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Headaches</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2. Concussion</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>3. Epilepsy / Seizure Disorder</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>4. Eye Condition</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>5. Anemia / Bleeding Disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Sickle Cell Trait or Disease</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Mononucleosis</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Meningitis</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Endocrine Condition (thyroid / diabetes)</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Heart Condition / Hypertension</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Lung Condition or Asthma</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Stomach / Intestinal Condition / Hepatitis</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Ruptured or Enlarged Spleen</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Bone or Joint Disease</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please explain all YES answers. (Attach a separate sheet if necessary.)

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Mental Health Care (Psychiatric or Psychological)
☐ Eating disorder (anorexia, bulimia)
☐ Depression/Anxiety/Bipolar disorder, etc.
☐ Suicidal thinking
☐ Alcohol/Drug treatment: Dates of treatment
☐ Outpatient care: Diagnosis, Dates of treatment, Medications
☐ Inpatient care: Diagnosis, Dates of treatment, Medications

Social Habits
Do you smoke? ☐ Yes ☐ No If yes, how much per day? For how many years?
Do you use alcohol? ☐ Yes ☐ No If yes, how much per week?
Are you on a special diet? ☐ Yes ☐ No If yes, what type?

Family History
Has any blood relative (maternal or paternal grandparents, parents, siblings) had any of the following?

<table>
<thead>
<tr>
<th>Other Medical Information</th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sickle cell anemia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart trouble</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast cancer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Seizure disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance abuse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other Medical Information
Please note any other pertinent information (e.g., use of eyeglasses, contact lenses, dentures, etc.) that you feel would be essential to Student Health Services to ensure that you receive complete medical care while at Wittenberg.

I hereby state that to the best of my knowledge, my answers to the above questions are correct and reviewed by a medical provider.

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Student’s Signature ____________________________ Date ____________________________

Medical Provider’s Signature ____________________________ Date ____________________________
# Wittenberg University Student Health Form

## Physical Exam

Note: All items must be completed within 12 months prior to enrollment at Wittenberg.

Patient’s Name: ___________________________ Date of Birth: ___________________________

Last Name: __________ First Name: __________ Middle Name: __________ Month/Date/Year: __________

Height: __________ Weight: __________ BP: __________

<table>
<thead>
<tr>
<th>Item</th>
<th>Normal</th>
<th>Abnormal</th>
<th>Note: Give details of each abnormality. Enter corresponding number before each comment.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Head, neck, face, and scalp</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Nose and sinuses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Mouth, teeth, gingiva, and throat</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Ears - general (canals, drums, etc.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Eyes - general (lids, pupils, motions, etc.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Lungs, chest, breasts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Heart</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Vascular system (include varicosities)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Abdomen and viscera (include hernia)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Ano-rectal and pilondal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Endocrine system</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Genito-urinary system</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Upper extremities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Lower extremities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Spine, other musculoskeletal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Skin and lymphatic (include acne)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Neurological system</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>18. If female, give menstrual history; specify medication.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medical history form has been reviewed and signed by physician? □ Yes □ No

Is student cleared for full participation in **all** intercollegiate varsity/club sports? □ Yes □ No

*If no:*

Is student cleared for participation in **non-contact** intercollegiate varsity/club sports? □ Yes □ No

Any history of emotional illness or eating disorders? □ Yes □ No

Present □ Yes □ No Past □ Yes □ No

Any special instructions for Student Health Services while the student if in school? □ Yes □ No

If there is an ongoing physical/emotional health problem, please send comments and recommendations for continued treatment/care to the health center.

Medical Provider’s Signature

Please print or stamp.

Name

Address

Telephone

---

Wittenberg University Health and Counseling Center, Ward Street at N. Wittenberg Ave., P.O. Box 720 Springfield, OH 45501

http://www.wittenberg.edu/administration/health_wellness.html | 937-327-7811 | Fax number: 937-327-7812
Certificate of Immunization

Name: ___________________________ Date of Birth: ___________________________

Last First Middle

Required of all Students

The information you provide on the form is strictly for the use of the Health and Counseling Center and the Sport Medicine Department and will not be released to anyone without your knowledge and consent. All full-time students must complete this form.

Required Immunizations:

A. MMR (Measles, Mumps, Rubella). Two live immunizations required on or after the first birthday, at least 30 days apart.
   1. Dose 1: _____/_____/_____  2. Dose 2: _____/_____/_____

A positive serological test for immunity to any of the above diseases is acceptable instead of immunizations.
A history of the disease is not acceptable.
Positive MEASLES titer: ____ Positive MUMPS titer: ____ Positive RUBELLA titer: ____

B. Tetanus-Diphtheria-Pertussis
   1. Primary series DTap or DTP 1. _____ 2. _____ 3. _____ 4. _____
   2. TDAP Booster (not Td or DT) within last 10 years: _____________

C. Polio
   1. Primary series (minimum three dates required):
      □ OPV (oral) □ IPV (injected): 1. _____ 2. _____ 3. _____ 4. _____

D. Tuberculosis screening (4-prong Tine test is not acceptable)
   PPD (Mantoux) test required within the last 12 months (regardless of prior BCG), before moving to campus.
   (BCG: Bacillus Calmette-Guerin is a vaccine to TB disease that is used in many foreign countries. Not recommended in the United States.)
   Tuberculosis skin Test:
   Date given: __________ Date read: __________
   Result mandatory: __________ (record actual mm of induration, transverse diameter; if no induration write “0”).
   Interpretation (based on mm of induration as well as risk factors)
   Positive □ or Negative □

If you have a positive TB skin test, additional testing may be requested.

Strongly Recommended Immunizations:

A. Hepatitis B immunization series
   Dose 1: _____/_____/_____  Dose 2: _____/_____/_____  Does 3: _____/_____/_____

B. Meningococcal vaccine _____/_____/_____  mo. day yr.

C. History of Chickenpox OR chickenpox vaccine
   1. Chickenpox _____/_____/_____  mo. day yr.
   2. Chickenpox vaccine _____/_____/_____  mo. day yr.

Medical Provider’s Signature ___________________________ Date ___________________________
Name

Insurance Information
Please copy both sides of your insurance card and attach to this page.

Primary Medical Insurance Company/Plan ___________________________________________________________
Primary Medical Insurance Company/Plan address ____________________________________________________
Name of Responsible Party ___________________________________________________________ Date of birth ____________
Social Security # __________ - _______ - __________ Relationship to Student __________________________
Insurance Contact/Claims Telephone # (_______) _________________________
Insurance Policy (ID) # ________________________________ Group (Control) # _____________________
Is the plan listed above considered Managed Care (HMO, PPO, POS, EPO) __________, or Traditional (FFS) __________?
Primary Dental Insurance Company/Plan ___________________________________________________________
Name of Responsible Party __________________________________________________________
Responsible Party Address (If different from above) __________________________________________________________
Social Security # __________ - _______ - __________ Relationship to Student __________________________
Insurance Contact/Claims Telephone # (_______) _________________________
Insurance Policy (ID) # ________________________________ Group (Control) # _____________________

Consent to Obtain Medical Information
I authorize Wittenberg University and its insurance provider to inspect or secure copies of case history records, laboratory reports, diagnoses, X-rays, and any other data covering pertinent pre-existing and incurred injuries, infirmities, confinements or disabilities. A photostatic copy or facsimile of this authorization shall be deemed as effective and valid as the original. I authorize Wittenberg University to obtain copies of any emergency room/ urgent care visits while the student is enrolled at Wittenberg University.

I authorize Wittenberg University or its insurance provider to pay medical vendors directly for any expenses covered under the university insurance program.

1. Parent/Guardian Signature* ______________________________________________  Date _____________________
   *Required only if student has not attained 18 years of age

2. Student Signature________________________________________________________  Date _____________________

Consent to Release Information To Parents
Students may consent online for campus health providers to be able to share information with parents or guardians. Go to “My Witt” and click on “Health Center Form” under “Family” on the right side of page. Follow directions there.
Consent to Treatment (to be completed only if student is not under the age of 18)

I, undersigned patient, in the event that there is a need for routine or emergency medical care that is the result of an injury and/or illness, authorize and give consent to the Wittenberg Health Center and Sports Medicine Department to administer all inpatient/emergency/outpatient medical care, encompassing routine diagnostic procedures and medical treatment by an attending physician, nurse practitioner, nurse, assistant, athletic training staff, consultant or designee, and any necessary mental health or substance abuse counseling, as is necessary in their professional judgment, in accordance with state law, and to refer me to duly licensed medical facilities and/or practitioners when indicated.

Student Signature: ____________________________ Date: ________________

Consent to Treatment of Minor (to be completed only if student is under the age of 18)

Students who are minors cannot be treated for health related services without parental or guardian consent unless: 1) the minor student is authorized by law to consent for treatment; or 2) obtaining informed consent is impracticable and a serious threat to the minor student’s life or health exists that must be dealt with immediately.

I, ____________________________________________ [name of parent, custodian or guardian],

residing at ____________________________________ [address],

certify that I am the ___________________________________________ [state relationship, e.g., parent or guardian] of ___________________________________________ [name of minor],

residing at __________________________________________ [address],

who is now ________ years of age.

In the event that there is a need for routine or emergency medical care that is the result of an injury and/or illness, I authorize and give consent to the Wittenberg Health Center and Sports Medicine Department to administer all inpatient/emergency/outpatient medical care, encompassing routine diagnostic procedures and medical treatment by an attending physician, nurse practitioner, nurse, assistant, consultant or designee, and any necessary mental health or substance abuse counseling, to ____________________________________________ [name of minor]

as is necessary in their professional judgment, in accordance with state law, and to refer ____________________________________________ [name of minor]

to duly licensed medical facilities and/or practitioners when indicated. For surgical procedures, or more extensive medical care, attempts will be made to contact me before such care is initiated.

I further understand that, once my child reaches the age of majority, my consent for treatment is no longer required.

Parent/Guardian Signature: ____________________________ Date: ________________
Wittenberg University Health Center Privacy Statement

**Your Privacy Is Important to Us**

Please review this document carefully. Wittenberg University Health Center is committed to protecting the information you share with us, and in turn respecting your privacy. This Privacy Statement will explain what type of information we keep, how we use your information and how we protect your information. Wittenberg University Health Center reserves the right to change this Privacy Statement at any time and will notify students of any changes required by law.

**What Information We Keep**

Wittenberg University Health Center understands your concerns regarding the confidentiality of information you share with us. We keep information that you share with us during your admission registration to the university, appointments and immunization information if you receive the immunization at our clinic. We keep information sent from other health care providers that assist in your health care. We collect this information to accurately identify you, understand your needs and provide excellent medical care. We refer you to outside providers as necessary and comply with federal, state and university regulations.

**What We May Disclose**

Unless we have written consent, we do not disclose any nonpublic personal information about patients or former patients to anyone, except as permitted by law. We may use the information you share with us internally to respond to or assist in improving our care, or in audits conducted by our accrediting bodies. Only with your written consent or to the extent permitted by law, may we share the information we keep with non-affiliated health care providers, professors, parents of students over 18 years of age or other parties.

**Protecting Your Personal Information**

Wittenberg University Health Center takes the security of your information very seriously and has established security standards and procedures to prevent unauthorized access to your medical information. We maintain physical, electronic and procedural safeguards to protect your information. Only authorized personnel within our organization who need to service your record, or who are involved in your care, see your information. These individuals are trained properly to handle confidential information and must abide by the terms of our confidentiality agreement.

**Former Students**

If you are no longer a student at Wittenberg University, we will adhere to the same information policies and practices to prevent unauthorized access to your medical information.

**Please sign, acknowledging that you have read the above. Return this form, along with the other forms, to the Wittenberg Health and Counseling Center, P.O. Box 720, Springfield, OH 45501.**
Wittenberg University Guide to the Health and Counseling Center and Sports Medicine

The Mission of our Health Center is to diagnose and treat illness, promote healthy behaviors and life-style choices through ongoing education, and to prepare students to be their own health advocates.

**Emergency:** The Springfield Fire Department Emergency Squad (911) is available in the event of a major accident, unconsciousness or a life-threatening emergency. The squad will transport students to Springfield Regional Medical Center Emergency Room in Springfield, Ohio.

**Hours:** The Health and Counseling Center is open from 8 a.m. - 5 p.m., Monday-Friday. The facility is closed when the university is not in session. A physician is available for appointments and phone calls during Health Center hours.

**Primary Care:** The center has both diagnostic and treatment capabilities.

The most frequently used services include: care of illness and injury, clinical lab testing, minor surgery such as suturing lacerations or removal of foreign bodies, administration of allergy vaccine, some immunizations, follow-up care after surgery or serious illness consultation and counseling on a confidential basis. We also provide reproductive services including examination, lab tests, treatment, counseling and education.

**Obtaining Services:** Students may make an appointment to see a physician by requesting the appointment in person at the Health Center or by calling ext. 7811 (off-campus 327-7811). Students are also accepted as walk-ins and are encouraged to visit the Health Center if they are ill regardless of whether the physician is present as communication between the registered nurses and the physician occurs during all Health Center hours.

**Confidentiality:** Records of all visits to the Health Center are strictly confidential. Information about the nature of an illness is not given to anyone (including faculty, administration or family) without the student's permission. This is in accordance with the Family Rights and Privacy Act. Information is released to public health agencies when required by law or to emergency personnel in case of urgent or life-threatening conditions.

**Allergy Injections:** When prescribed by a student's personal physician, injections can be continued at the Health Center. The student supplies the allergy extract and written instructions from the prescribing physician. The extract is stored at the Health Center to ensure proper handling. Students needing to receive allergy injections should plan to meet with the doctor as soon as possible after their arrival on campus. Instructions and precautions for allergy injections will be discussed, and the student will be asked to sign a contract indicating a willingness to comply with the guidelines.

**Substance Abuse Prevention:** Education, intervention and treatment services are available to students experiencing problems with alcohol and other drug use. We also provide individual substance abuse assessments, group education programs and consults to those concerned about another's use. Referrals to community resources may include outpatient and inpatient treatment as well as drug screening.

All services are confidential and are available by calling ext. 7811.

**Location:** The Health and Counseling Center is located in the Shouvlin Center basement, Room 003.

**Sports Medicine Care:** The front page of the Health Record will be used in the event of athletic medical emergencies at home or on the road. Please take a moment and complete all insurance information as this will help expedite outpatient services if necessary and will address various required authorizations.

New student athletes please bring clearance notes from any treating physician of athletic injury or surgery. We will conduct yearly screenings for all athletes. In the event of a major illness or injury, if the athlete has been hospitalized, or the athlete has been evaluated for a change in health status as it applies to athletic participation, we require a letter of full or limited clearance from the physician to resume participation in their sport. All students who have had surgery with the last year must have a letter of full or limited clearance to resume participation from their respective operative physician. This allows us the opportunity to ensure complete and compliant continuity of care to serve you better.

All athletic related injuries will be referred to Wittenberg Sports Medicine, however, students injured while participating in a club sport will need to report to the Health Center.

**Billing:** The student Health Center does not bill insurance. Charges incurred at the Health Center are billed to the student account. Wittenberg does not bill private insurance. Students are provided a copy of the bill to submit to private insurance for reimbursement.

**Medical Excuse Policy:** Students are responsible for notifying professors of absence from class due to short-term illness or injury. The student Health Center will verify on request that a student has been seen or treated in the Health Center, but confidentiality is maintained and a reason for the visit and/or diagnosis will not be discussed without written permission from the student.

Under no circumstances will we verify illness or absence for anyone not treated by staff here at the Health Center.

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Wittenberg University Health and Counseling Center, Ward Street at N. Wittenberg Ave., P.O. Box 720 Springfield, OH 45501
http://www.wittenberg.edu/administration/health_wellness.html | 937-327-7811 | Fax number: 937-327-7812
Wittenberg University Options for Health Care

Wittenberg Medical Facilities
Wittenberg Health and Counseling Services
Shouvlin Center Room 003
737 N. Fountain Ave.
Springfield, OH
(937) 327-7811

Local Medical Facilities
Springfield Regional Medical Center
100 Medical Center Drive
Springfield, OH
(937) 523-1000

Local Urgent Care Facilities
Community Urgent Care
2200 N. Limestone Street
399-5303
9 a.m. - 8 p.m. Monday-Saturday
11 a.m. - 5 p.m. Sunday

Community Urgent Care
2555 N. Creekwood Court
327-0552
9 a.m. - 8 p.m. Sunday-Saturday

Hometown Urgent Care
1301 West First Street
(937) 322-6222
8:30 a.m. - 7:30 p.m. Monday-Friday
9 a.m. - 5 p.m. Saturday/Sunday

Hometown Urgent Care
1200 Vester Ave.
(937) 342-9520
8:30 a.m. - 7:30 p.m. Monday-Friday
9 a.m. - 5 p.m. Saturday/Sunday

Local Pharmacies
Madison Avenue Pharmacy
Corner of Fountain and Ward Street
640 N. Fountain Avenue
323-1841

Walgreens
1140 N. Limestone
325-7680

Wal-Mart
2100 N. Bechtle
399-2045

CVS Pharmacy
2987 Derr Road
390-2500
1475 Upper Valley Pike (Mall)
323-9129

Rite-Aid
401 W. North
324-5796

Kroger
965 Bechtle Avenue
323-0282
2300 N. Limestone
328-7050
2989 Derr Road
390-0767

Local Mental Health Services
Mental Health Service of Clark County
1345 N. Fountain Ave,
399-9500
Emergency Service available 24 hours a day

Talk-one-2-one
1-800-756-3124
After hours anonymous phone consultation