MUSC Health
Medical University of South Carolina
at
THE CITADEL

Student Health Services
Phone: 843-953-4827
Email: citadel@musc.edu

Dear Student and Parent(s):

Congratulations on your academic acceptance to The Citadel. The Citadel Surgeon and his staff are pleased to offer exceptional care for the Corps of Cadets and look forward to extending these services to you. Included in this packet are the required forms to complete your medical enrollment with MUSC Health at The Citadel, and provide our clinic essential medical information to assist in your healthcare. Additional instructions are listed below. Please read these thoroughly.

1. **Medical forms are due by June 1st.**
2. **Medical insurance is mandatory for Cadets.** Primary medical care will be provided at the campus infirmary, MUSC Health at The Citadel. Insurance will be billed for services; therefore, Cadets need to ensure coverage will remain active during the entire period they are enrolled at The Citadel. If there is a change in coverage at any point, insurance information needs to be updated with MUSC Health at The Citadel. International students are required to be covered by health insurance meeting federal and college standards, and may contact the "Citadel Center for International Studies" for specific coverage requirements.
3. The medical packet will need to be reviewed and completed thoroughly. Please ensure all signatures and your CWID are present as needed prior to submission. The completed packet (all pages following this letter) should be emailed to the MUSC Health at The Citadel secure email: **citadel@musc.edu**
4. Page 2: Please include all demographic and current insurance information.
5. Pages 3-4: Authorization for information disclosure and consent to treat to be completed by the Cadet applicant
6. Page 5: Please obtain or update all mandatory immunizations prior to matriculation and provide proof of administration along with remainder of immunization record.
7. Pages 7-10: Please complete past medical history form and present to your physician or advanced practice provider for review during your physical examination. Body measurements and physical examination completed by an unrelated licensed DO, MD, NP or PA.
8. Upon receipt of the documents the Citadel Surgeon and MUSC Health at The Citadel staff will review all forms for completion. Additional information may be requested only if necessary for the safety of a Cadet applicant due to the physically rigorous and emotionally/psychologically demanding nature of The Citadel.
9. If the Cadet applicant develops a significant illness or injury after submitting the medical application please notify MUSC Health at The Citadel as soon as possible so the health record can be updated.

We look forward to partnering with you to be sure all medical information is received and that you can safely attend The Citadel

Sincerely,

The MUSC Health at The Citadel Team
Phone: 843-953-4827
Email: citadel@musc.edu

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Patient Demographic Information

CWID:_____

Last Name:	First Name:	Middle Initial:
Date of Birth:	SSN:	Marital Status:
Home Address:		
Home Phone:	Cell Phone:	Email:
Parent/Guardian:		Cell Number:
Preferred Gender:		Language:
Are you a veteran: Yes / No	Ethnicity Other:	Hispanic or Latino / Not Hispanic or Latino
Race (please circle one): American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or Pacific Islander White or Caucasian / Refuse		

Patient Insurance Information

Insurance Company Information		
Insurance Company Name:	Insurance Company Claims Address (back of card):	
Insurance Company Phone Number:	Policy/ID Number and Issue Date:	Group Number:
Subscriber (Policy Holder) Information		
Subscriber Name (first & last):	Cell Phone:	Email:
Subscriber Date of Birth:	Subscriber Gender	Service Member SSN (TriCare Only)
Copies of the front and back of the insurance card are required- please sent with the completed packet		

Front of Insurance Card

Back of Insurance Card

AUTHRELSE

MUSC Health at The Citadel
Authorization to Disclose Protected Health Information

Form Origination Date: 6/2022
Version: 1 Version Date: (6/2022)

CWID:_____

Patient Name _____

MRN_____

PATIENT IDENTIFICATION LABEL

Patient Name: _____
(print legal name of patient/Citadel applicant)

All healthcare information is private. MUSC will share the above patient/student's protected health information with The Military College Infirmary a/k/a The Citadel Infirmary as necessary for continuum of care of the patient.

By signing this authorization form, the above-named patient/student, authorizes MUSC to share and disclose a limited subset of protected health information, with The Military College a/k/a The Citadel. Disclosure is authorized for the purpose of allowing The Citadel, during the student's enrollment, to take appropriate actions where medically indicated and or provide medically necessary leaves, accommodations, restrictions and or modifications to school related activities as necessary for the wellbeing of their students. The purpose of this authorization, is to allow The Citadel, during the student's enrollment, to facilitate or provide medically necessary leaves, accommodations, restrictions and or modifications to school related activities.

Examples of protected health information that may be shared, include but are not limited to: dates and times when the patient/student was seen at MUSC, recommendations for quarantine, contact tracing, bed rest, medical leave, recommendations and/or restrictions related to uniform compliance and/or involvement in activities and or cadet duties.

MUSC will share protected health information with The Citadel using a minimum necessary standard.

I understand that this information may be exchanged by mail, fax, email, phone, or a secure web-based software.

I understand that I have a right to cancel this permission at any time. I understand that if I cancel this permission I must do so in writing and present my written cancellation to the MUSC at The Citadel clinic. I understand that the cancellation will not apply to information that has already been released in response to this permission, as stated in the Notice of Privacy Practice. I understand this consent form is valid until I revoke it or am no longer enrolled at the Citadel.

I understand that permitting the release of protected health information is voluntary. I can refuse to sign this form. I do not need to sign this form to receive treatment. I understand I may review and/or copy the information disclosed, as provided in 45 CFR 164.524.

I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person/organization receiving the information. Upon request, I understand I will be given a copy of this authorization. Parental consent for release of health information is not required for students who are 18 years or older.

_____ _____
Signature of Patient or Legal Guardian/Representative Date
(or Student if 18 years or older or otherwise permitted by law)

_____ _____ _____
Witness Printed Name Witness Signature Date

_____ _____
Printed Name Patient or Legal Guardian/Representative Date
(or Student if 18 years or older or otherwise permitted by law)

_____
Relationship to Patient

MUSC Health
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THE CITADEL

Student Health Services
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Email: citadel@musc.edu

VACCINATION RECORDS

CWID:_____

Mandatory Vaccinations

ANTIBODY TITER	**MONTH / DAY / YEAR**	**TITER RESULTS :**			
Measles / Rubeola IgG		☐ **Immune**	☐ Equivocal / Borderline	☐ Negative / Non-Immune	☐ **Lab Report Attached**
Mumps IgG		☐ **Immune**	☐ Equivocal / Borderline	☐ Negative / Non-Immune	☐ **Lab Report Attached**
Rubella IgG		☐ **Immune**	☐ Equivocal / Borderline	☐ Negative / Non-Immune	☐ **Lab Report Attached**
MMR VACCINES	**MONTH / DAY / YEAR**	**Verifying Documentation Attached**			
#1 Measles---Mumps---Rubella					
#2 Measles---Mumps---Rubella					
ANTIBODY TITER	**MONTH / DAY / YEAR**	**TITER RESULTS: Negative / Equivocal / Borderline / Indeterminate Titer requires vaccination.**			
Varicella IgG Titer:		☐ **Immune**	☐ Equivocal / Borderline	☐ Negative / Non-Immune	☐ **Lab Report Attached**
VARICELLA VACCINES	**MONTH / DAY / YEAR**	**Verifying Documentation Attached**			
#1 Varivax					
#2 Varivax					
TETANUS VACCINES	**MONTH / DAY / YEAR**	**Verifying Documentation Attached**			
Tetanus/Diphtheria/Pertussis (Tdap)					
Tetanus/Diphtheria (Td)					
Meningitis Vaccine Proof of Vaccination after age 16 OR Signed Waiver	**MONTH / DAY / YEAR**	☐ Menactra ☐ Menveo ☐Menomune ☐ Unknown **(Attach Documentation of Vaccination)** ☐ I do not wish to receive the meningococcal vaccine. I have read the information and completed the on-line form at https://lifenet.musc.edu			

Recommended Vaccinations

Primary Hepatitis B Vaccine Series	**Dose #1** ___/___/___ MONTH/ DAY / YEAR	**Dose #2** ___/___/___ MONTH/ DAY / YEAR	**Dose #3** ___/___/___ MONTH/ DAY / YEAR	☐ **Attach documentation of vaccination**
	Hepatitis B Surface IgG Antibody Titer Date_____	☐ **Immune Titer**	**Non – Immune Titer** ☐ Equivocal/ Borderline ☐ Negative	☐ **Lab Report Attached**
		_____mIU/mL Titer Result	Equivocal or Negative Titers – see Page 1	

	Dose #4	**Dose #5**	**Dose #6**	
Secondary Hepatitis B Vaccine Series (If Non-Immune After Primary Series)	___/___/___ MONTH/ DAY / YEAR	___/___/___ MONTH/ DAY / YEAR	___/___/___ MONTH/ DAY / YEAR	☐ **Attach documentation of vaccination**
	Hepatitis B Surface IgG Antibody Titer Date_____	☐ **Immune Titer**	**Non – Immune Titer** ☐ Equivocal/ Borderline ☐ Negative	☐ **Lab Report Attached**
		_____mIU/mL Titer Result	Equivocal or Negative Titers – see Page 1	

Hepatitis B Vaccine Non-responder (If Hepatitis B Surface Antibody Negative after Primary and Secondary Series)	**Date:**	Hepatitis B Surface Antigen (If 2nd titer is negative)	**(Attach Lab Report)**
	Date:	Hepatitis B Core Antibody (If 2nd titer is negative)	**(Attach Lab Report)**
Chronic Active Hepatitis B	**Date:**	Hepatitis B Surface Antigen	**(Attach Lab Reports)**
	Date:	Hepatitis B Viral Load (PCR)	

Covid-19 Vaccine	**Dose #1** ___/___/___ MONTH/ DAY / YEAR (circle one) Pfizer Moderna J&J	**Dose #2** ___/___/___ MONTH/ DAY / YEAR (circle one) Pfizer Moderna J&J	**Dose #3** ___/___/___ MONTH/ DAY / YEAR (circle one) Pfizer Moderna J&J