Dear Student:

Welcome to the Manhattanville College Student Health Center. We offer primary medical care, women’s health services, and referrals to specialists for all full-time undergraduate students, English as a second Language Program, part-time undergraduate resident and graduate resident students. Health services provided by our physician, nurse practitioner and nurses are free of charge to our students. However, there may be modest charges for immunizations, certain tests, treatments, or medications. These charges are subsidized and in some cases can be covered by insurance.

Health insurance at Manhattanville College is mandatory. An unexpected medical bill can interrupt a college career. If you are not covered by your parent’s health insurance then you are required to buy the Manhattanville College student health insurance. All laboratory work not covered by the student’s medical insurance will be the financial responsibility of the student. The health history, physician’s examination, and immunization record are the foundation of the student’s medical record at the college. A thorough baseline medical record enables better healthcare for students during their college career. The information contained in your medical records is held with the strictest confidentiality.

We look forward to meeting and working with you to ensure your health and well-being while attending Manhattanville College.

If you have any questions or concerns, please call us at (914) 323-5245.

Sincerely,

Student Health Center
Student Health Requirements

Please return the completed forms by mail or fax:
Manhattanville College
Student Health Center
2900 Purchase Street
Purchase, NY 10577
T: (914)-323-5245
F: (914)-323-5257

Questions?
If you have any questions or concerns, please contact the Health Center at:
914-323-5245

The following forms are due as follows:
- for Fall enrollment by July 15
- for Spring enrollment by January 6

STUDENT CHECKLIST—Please ensure the following are on file in the Student Health Center

☐ Part 1—Personal Information
To be filled out by students and parents/guardians.

☐ Part 2—Student Health Form—Health History Section
To be filled out by students and parents/guardians.
All medical/psychiatric problems should be included in this section as well as any medications being taken by the student and any allergies to medications. It is essential that the Student Health Center is advised of any diagnosis or disorder so that proper medical assistance can be offered in the case of illness or an emergency. If you have a chronic medical condition or a significant medical, psychiatric or disabling condition, make sure a copy of all pertinent records is sent to the health center with the health form.

☐ Part 3—Student Health Form—Physical Exam and Immunization Section
To be filled out by your private healthcare practitioner. The first part has a section for the student to fill out if participating in athletics.
The New York State Department of Health requires documentation of immunity for mumps, measles and rubella (MMR). It is also highly recommended that students receive the meningococcal vaccine prior to college matriculation.
Failure to provide documentation of MMR immunization can result in a fine of $2000 from the Westchester County Health Department payable to the student and/or parents. Without documentation, students will not be able to attend class or reside in residence halls.

☐ Part 4—Meningitis Vaccine/Waiver
This section is for you and your parents/guardians to read and fill out. If a student does not wish to receive the Meningitis vaccine the waiver MUST be signed.

☐ Part 5—Notice of Privacy Practices
This section is for you and your parents/guardians to read and fill out.
PART 1—Personal Information

Student Contact Info

Student name__________________________________________  DOB _______/_______/_______
Student address______________________________________________________________________________________
Cell phone (__________) _________________________________  Expected year of graduation _________________________
Class entering: ☐ Freshman      ☐ Sophomore      ☐ Junior      ☐ Senior
Sex:      ☐ Male      ☐ Female
Enrollment status: ☐ Full-time      ☐ Part-time

Emergency Contacts

In case of emergency, please call:

Mother’s name __________________________________________ Day Telephone (_______) ________________________________
Cell (_______) ________________________________________ Evening (_______) ________________________________
Father’s name __________________________________________ Day Telephone (_______) ________________________________
Cell (_______) ________________________________________ Evening (_______) ________________________________
Other contact __________________________________________ Day Telephone (_______) ________________________________
Cell (_______) ________________________________________ Evening (_______) ________________________________
Primary Physician name_______________________________  Telephone (_______) ________________________________

Medical Insurance

Please be advised that if you have no medical insurance coverage, there is mandatory enrollment in a health plan offered through Manhattanville College. Please provide a copy of your insurance card (front and back) if covered by outside insurance.

Family insurance _____________________________________  Name of carrier ________________________________
Address _____________________________________________________________________________________________
Policy/ID# __________________________________________  Group name and # ________________________________
Subscriber’s name and address _____________________________________________________________________________

School insurance _____________________________________  Name of carrier ________________________________

Consent

If you are under the age of 18 upon entering Manhattanville College, a record of parental or guardian authorization for medical treatment must be on file in our office in order for us to facilitate your health care. The following information is required:

Student’s name ________________________________________ Date of birth _______/_______/_______
Name of Parent/Guardian ____________________________________________
Parent/Guardian home address ______________________________________

Parent/Guardian Phone Numbers Day (_______) ____________________________ Evening (_______) ______________________

The undersigned hereby authorizes and grants permission to Student Health Center, or its designate, to administer treatment to the student named on this form.
PART 2—Student Health Form—Health History Section
(to be filled out by student and/or parents/guardians)

Medical History
Do you have any chronic medical conditions? ☐ yes ☐ no
If yes, please describe_______________________________________________________________________________________________

Do you have or have you had any of the following? (Check all that apply):
5. ☐ Arthritis 15. ☐ Heart Disease/Problem 25. ☐ Migraines/Chronic Headaches
31. ☐ Seizure Disorder
32. ☐ Sickie Cell Disease
33. ☐ Thyroid
34. ☐ TB/tuberculosis
35. ☐ Ulcer/Stomach Problem
36. ☐ UTIs(Frequent/Recurrent)
37. ☐ Other __________________

Have you ever had any surgeries? ☐ yes ☐ no
If yes, please explain type of surgery and date____________________________________________________________________________

Do you require any assistive devices? ☐ yes ☐ no
If yes, please explain _______________________________________________________________________________________________

Medications (list all medications including prescription and over the counter medications)

<table>
<thead>
<tr>
<th>Name of Medication and Dose</th>
<th>Condition Being Treated</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Allergies
Allergies to Medications_________________________
Type of reaction__________________________________________________________
Other allergies_________________________
Type of reaction__________________________________________________________

Family History
Have any immediate relatives (parents, siblings) ever had any of the following:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>Relationship</th>
<th></th>
<th>Yes</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcoholism</td>
<td></td>
<td></td>
<td>High Blood Pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergies</td>
<td></td>
<td>Kidney Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood or Clotting Disorders</td>
<td></td>
<td>Neuromuscular Disorder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td>Mental Illness</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Diabetes</td>
<td></td>
<td>Stroke</td>
<td></td>
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<td></td>
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<tr>
<td>Heart Disease</td>
<td></td>
<td>Tuberculosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Cholesterol</td>
<td></td>
<td>Other Serious Illness</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
PART 3—Student Health Form—Physical Exam and Immunization Section (first part to be filled out by student if an athlete, the remainder to be filled out by private healthcare practitioner)

Are you or do you plan to be on any Manhattanville College athletic team(s)? ☐ yes ☐ no
If yes, please list teams______________________________________________________________________________________________________

Please sign your name authorizing the Student Health Center upon request to release a copy of your physical examination to the Department of Athletics for your medical chart.
_______________________________________________________________________________________________________(Signature and Date)

**Physical Exam**

*(must be performed within one year prior to enrollment)* Date of Exam ____/____/____

Height _______________ Weight _______________ BP ________________ Pulse ________________ Flow (if asthmatic)________________

Sickle Cell Blood Test (for athletes only): ☐ Negative ☐ Positive ☐ Disease

Allergies to Medications ____________________________________________________________________________________________________

Current and Chronic Medical Problems _______________________________________________________________________________________

If the student is under care for a chronic or serious illness, please describe below and attach additional clinical reports to assist us when the student is under our care. __________________________________________________________________________________________________________

<table>
<thead>
<tr>
<th>Medical</th>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>General appearance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HEENT/Nodes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest, Heart, Pulses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breasts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitalia</td>
<td></td>
<td></td>
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<tr>
<td>Extremities and Spine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurological and Psychiatric</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Athletic Participation**

Is the student medically cleared to participate in athletics if applicable? ☐ yes ☐ no
If no, please explain______________________________________________________________________________________________

Healthcare Provider (licensed physician or nurse practitioner)

Practitioner signature and STAMP: __________________________________________________________

Practitioner name, address and phone:__________________________________________________________
## REQUIRED IMMUNIZATIONS

Measles (2 doses after 1 year of age), mumps (2 doses after 1 year of age) and rubella (1 dose after 1 year of age). Exact dates are required for all immunizations. Proof of immunity by titer is also acceptable, copy of results must be attached.

**MMR**: (2 doses required on or after 1st Birthday or immune by titer)
- ☐ 1st dose _______/_______/_______ and ☐ 2nd dose _______/_______/_______ or ☐ immune by _______/_______/_______ OR

**Measles**: (2 doses required on or after 1st birthday or immune by titer)
- ☐ 1st dose _______/_______/_______ and ☐ 2nd dose _______/_______/_______ or ☐ immune by _______/_______/_______

**Mumps**: (2 doses required on or after 1st birthday or immune by titer)
- ☐ 1st dose _______/_______/_______ and ☐ 2nd dose _______/_______/_______ or ☐ immune by _______/_______/_______

**Rubella**: (1 doses required on or after 1st birthday or immune by titer)
- ☐ 1st dose _______/_______/_______ and ☐ 2nd dose _______/_______/_______ or ☐ immune by _______/_______/_______

## REQUIRED TESTS

**TB Test (PPD or Quanteferon)**: (must be dated within 1 year of enrollment)
- PPD: Date _______/_______/______ Result in mm______ and/or Q-Gold: Date _______/_______/______ Result ____ (attach official lab report)
- CXR (if above positive): ☐ normal ☐ abnormal Date _______/_______/______ (attach report) Txmt: ☐ Yes ☐ No Date _______/_______/______

**Meningococcal quadrivalent**: ☐ Not vaccinated (must sign waiver in Part 4) ☐ Vaccinated: Date of vaccine _______/_______/______

## RECOMMENDED IMMUNIZATIONS/TESTS

**Tetanus**: Had primary series (3)? ☐ yes ☐ no Date of last dose in series _______/_______/______
- Date of most recent booster: _______/_______/______ Type of booster ☐ Td ☐ Tdap

**Polio**: ☐ IPV ☐ OPV ☐ IPV/OPV sequential Had primary series (3)? ☐ yes ☐ no
- Dose 1: _______/_______/_____ Dose 2: _______/_______/_____ Dose 3: _______/_______/_____ Dose 4 (if IPV/OPV): _______/_______/_____ or

**Hepatitis B**: ☐ Not Vaccinated or ☐ Dose 1: _______/_______/______ Dose 2: _______/_______/______ Dose 3: _______/_______/______ or
- Hepatitis B surface antibody: ☐ Reactive ☐ Non-reactive Date _______/_______/______

**Varicella**: ☐ History of disease or Varicella antibody: ☐ Reactive ☐ Non-reactive Date _______/_______/______ or
- ☐ 1st Dose: _______/_______/______ and 2nd Dose: _______/_______/______

Healthcare Provider (licensed physician or nurse practitioner)

Practitioner's signature

______________________________ STAMP:

Practitioner's printed name, address and phone

____________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________
Meningitis Vaccine

The New York State Department of Health requires documentation of immunity for mumps, measles and rubella (MMR). It is also highly recommended that students receive the meningococcal vaccine prior to college matriculation. If students do not wish to receive the meningitis vaccine, the waiver must be signed. Check one box and sign below. The student below has:

☐ Had the meningococcal meningitis immunization within the past 10 years. Date received____________________.

☐ Read or has had explained to me the information regarding meningitis. I (the student) understand the risks of not receiving the vaccine, and have decided not to obtain the immunization against meningococcal meningitis disease.

___________________________________________
Student signature

___________________________________________
Parent/Guardian signature (if student is under 18 years old)
PART 5—Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to it. Please review it carefully. The privacy of your health information is important to us.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect.

You may request a copy of this Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use and disclose your health information to a physician or other healthcare providers providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so. We will ask for your permission in writing.

Persons Involved In Care: We may use or disclose your health information to assist in the notification of your location, your general condition, or your death to a family member, your personal representative, or another person responsible for your care. If you are present, then prior to use or disclosure, we will provide you with an opportunity to object to such uses. In the event of your incapacity or in emergency circumstances, we will disclose your health information based on our professional judgment. We will make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Law Enforcement: We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Patient Rights

Access: You have the right to look at or get copies of your health information with limited exceptions. You must make a request in writing to obtain access to your health information.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Amendment: You have the right to request that we amend your health information. You request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

By signing below, I acknowledge that I have received a copy of this Notice of Privacy Practices. I also consent to the use and disclosure of my medical information to treat me and arrange for my medical care, to seek and receive payment for the services provided to me, and for the business operation of the Manhattanville College Student Health Center.

Name ___________________________________________________________ Date _______ /_______/ _______

Student signature Parent signature (if student is under 18 years old)