



Manhattanville
COLLEGE®

Congratulations on joining the Manhattanville family! The staff welcomes you to the Valiant community and looks forward to supporting your health needs.

The medical staff in Health Services includes one full-time board certified nurse practitioner, one part-time board certified nurse practitioner, and two registered nurses. The staff provides medical care, women's health services, and referrals to specialists as needed. Services are provided for all full-time undergraduate students and residential graduate students. Services are generally without cost with the exception of immunization, laboratory services, and prescription medications. Costs not covered by insurance will be the financial responsibility of the student.

Health insurance is required for all students enrolled at the College. If you are not eligible for coverage under a family member's plan, Manhattanville College offers student health insurance through Aetna Student Health. Information about this plan can be found at www.aetnastudenthealth.com. This coverage can be waived with evidence of comparable health insurance coverage. Please visit the Office of Student Accounts webpage for additional information www.mville.edu/admissions/financial-aid-scholarships/student-accounts. The waiver form can also be found on this webpage. If you have questions concerning the student health insurance, please contact Student Accounts at 914.323.5266.

The student health packet provides health services with information necessary to treat you. ***Immunization information is required by law and must be on file with health services prior to the start of the semester.*** Your health history establishes a medical record and allows Student Health and Counseling to provide optimal care for you. All medical documents are held with strict confidentiality.

We look forward to helping keep you healthy and well throughout your time at Manhattanville College. If you have any questions or concerns, please feel free to call us at 914.323.5245.

Sincerely,



Manhattanville College
Student Health and Counseling

Spellman Hall – Ground Floor
2900 Purchase Street
Purchase, NY 10577

PHONE 914.323.5245

FAX 914.323.5257

EMAIL shac@mville.edu



Name _____

DOB _____

Please return the completed forms by email, fax, or mail to:

Manhattanville College
Student Health and Counseling
Health Services

Spellman Hall Ground Floor
2900 Purchase Street
Purchase, NY 10577

P 914.323.5245

F 914.323.5257

Email shac@mville.edu

The following forms are due as follows:

- for fall enrollment – **by July 15**
- for spring enrollment – **by January 6**

Checklist for Incoming Students

PLEASE REVIEW CAREFULLY

PART 1 – PERSONAL INFORMATION

To be completed by student and parents/guardians

PART 2 – STUDENT HEALTH FORM – HEALTH HISTORY SECTION

To be completed by students and parents/guardians

All medical histories should be completed in this section, including any medications taken by the student and any allergies to medications. It is essential that the Student Health Center is aware of a student's medical history 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 or disabling condition, make sure copies of all pertinent records are sent to the health center with the health form.

PART 3 – IMMUNIZATION SECTION

To be completed by your healthcare provider

The New York State Department of Health requires documentation of two (2) measles, mumps and rubella (MMR) vaccine doses. It is recommended the students receive the meningitis vaccine within five (5) years of college enrollment. If they chose not to receive the meningitis vaccine, they will need to sign the meningitis waiver. Additionally, students attending Manhattanville are required to have been vaccinated for COVID-19. Prior to the start of the semester, students must provide documentation of ALL mandatory vaccines. If documentation is incomplete, a "HOLD" will be placed on the student's account. This hold will delay class and residence hall registrations and may also prevent the student from coming onto the campus.

PART 4 – MENINGITIS VACCINE WAIVER

If a student does not wish to receive the meningitis vaccine, or the meningitis vaccine was received more than five (5) years prior to enrollment, this waiver **MUST** be signed.

PART 5 – NOTICE OF PRIVACY PRACTICES

This section is for the student and your parents/guardians to read and complete



Name _____

DOB _____

Part 1 – Personal Information

STUDENT CONTACT INFO

Student Name _____ DOB _____

Student Address _____

Phone _____ Expected year of graduation _____

Class entering: First-year 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 _____

Father's name _____ Day telephone _____

Cell _____

Other contact _____ Day telephone _____

Cell _____

Primary Physician Name _____ Telephone _____

MEDICAL INSURANCE: *Please provide a copy of your insurance card (front and back).*

Please be advised that if you do not have medical insurance coverage, there is mandatory enrollment in Aetna Student Health, offered through Manhattanville College. Please log on to <https://www.aetnastudenthealth.com> to enroll in the school insurance.

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. The following information is required:

Student's name _____ DOB _____

Name of Parent/Guardian _____

Parent/Guardian home address _____

Parent/Guardian phone numbers

Day telephone _____ Cell _____

The undersigned hereby authorizes and grants permission to Student Health, or its designate, to administer treatment to the student named on this form.



Name _____

DOB _____

Part 2 – Student Health Form

(HEALTH HISTORY SECTION) *(To be filled out by student and/or parents/guardian)*

MEDICAL HISTORY

Do you have chronic medical conditions? Yes No

If yes, please describe _____

Do you have or have you had any of the following? (Check all that apply):

- | | | | |
|--|--|--|---|
| 1. <input type="checkbox"/> Acne | 11. <input type="checkbox"/> Deaf/Hearing Impairment | 21. <input type="checkbox"/> Kidney Stone | 31. <input type="checkbox"/> Seizure Disorder |
| 2. <input type="checkbox"/> Anemia | 12. <input type="checkbox"/> Depression | 22. <input type="checkbox"/> Kidney Disease | 32. <input type="checkbox"/> Sickle Cell Disease |
| 3. <input type="checkbox"/> Anorexia Nervosa/Bulimia | 13. <input type="checkbox"/> Diabetes | 23. <input type="checkbox"/> Learning Disability | 33. <input type="checkbox"/> Thyroid |
| 4. <input type="checkbox"/> Appendectomy | 14. <input type="checkbox"/> Emotional/Mental Illness | 24. <input type="checkbox"/> Malaria | 34. <input type="checkbox"/> TB/Tuberculosis |
| 5. <input type="checkbox"/> Arthritis | 15. <input type="checkbox"/> Heart Disease/Problem | 25. <input type="checkbox"/> Migraines/Chronic | 35. <input type="checkbox"/> Ulcer/Stomach Problem |
| 6. <input type="checkbox"/> Asthma | 16. <input type="checkbox"/> Hepatitis (Type____) | 26. <input type="checkbox"/> Mononucleosis | 36. <input type="checkbox"/> UTIs
(Frequent/Recurring) |
| 7. <input type="checkbox"/> Blind/Visual Impairment | 17. <input type="checkbox"/> High Blood Pressure | 27. <input type="checkbox"/> Neuromuscular | 37. <input type="checkbox"/> Other _____ |
| 8. <input type="checkbox"/> Cancer/Malignancy | 18. <input type="checkbox"/> High Cholesterol | 28. <input type="checkbox"/> Phlebitis/Vein Clot | |
| 9. <input type="checkbox"/> Chickenpox | 19. <input type="checkbox"/> HIV Disease | 29. <input type="checkbox"/> Pneumothorax | |
| 10. <input type="checkbox"/> Colitis/Ileitis | 20. <input type="checkbox"/> Impaired Mobility/Paralysis | 30. <input type="checkbox"/> Positive TB | |

Have you ever had any surgeries? Yes No

If yes, please explain type of surgery and date _____

Do you require assistive devices? Yes No

If yes, please explain _____

MEDICATION *(list all medications including prescription and over the counter medications)*

NAME OF MEDICATION AND DOSE	CONDITION BEING TREATED

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:

	YES	RELATIONSHIP		YES	RELATIONSHIP
ALCOHOLISM			HIGH BLOOD PRESSURE		
ALLERGIES			KIDNEY DISEASE		
BLOOD OR CLOTTING DISORDERS			NEUROMUSCULAR DISORDER		
CANCER			MENTAL ILLNESS		
DIABETES			STROKE		
HEART DISEASE			TUBERCULOSIS		
HIGH CHOLESTEROL			OTHER SERIOUS ILLNESS		



Name _____

DOB _____

Part 3 – Immunization Section

(to be completed by healthcare provider)

MANDATORY IMMUNIZATIONS

(New York State Health Law) Exact dates (MM/DD/YYYY) are required for all immunizations. Proof of immunity by titer is also acceptable. Copy of lab results must be attached.

MMR: (2 doses required, 1st dose must be on or after 1st Birthday)

1st dose ___/___/___ and 2nd dose ___/___/___ or immune by ___/___/___

OR

MEASLES: (2 doses required, 1st dose must be on or after 1st Birthday)

1st dose ___/___/___ and 2nd dose ___/___/___ or immune by ___/___/___

MUMPS: (2 doses required, 1st dose must be on or after 1st Birthday)

1st dose ___/___/___ and 2nd dose ___/___/___ or immune by ___/___/___

RUBELLA: (2 doses required, 1st dose must be on or after 1st Birthday)

1st dose ___/___/___ and 2nd dose ___/___/___ or immune by ___/___/___

MENINGITIS VACCINE:

Not vaccinated (MUST sign waiver in Part 4) Vaccinated: Date of vaccine ___/___/___

NOTE: Must be vaccinated within five years of enrollment

COVID-19 VACCINE:

Name of vaccine received : _____ (Moderna, Pfizer, Janssen/Johnson & Johnson)

Date of vaccine: 1st Dose: ___/___/___ 2nd Dose: ___/___/___

ADDITIONAL IMMUNIZATIONS (Recommend attaching electronic immunization record)

Tetanus: Date of most recent booster: ___/___/___ Type of booster Td Tdap

Varicella: History of disease of Varicella antibody: Reactive Non-reactive Date ___/___/___ or 1st dose ___/___/___ and 2nd dose ___/___/___

Healthcare Provider (Licensed Physician or Nurse Practitioner): _____

Provider Signature and Stamp: _____

Provider name, address and phone: _____

Date: _____



Name _____

DOB _____

Part 4 – Meningococcal Vaccination

MENINGOCOCCAL VACCINATION RESPONSE FORM

New York State Public Health Law requires that all college and university students enrolled for a least six (6) credits complete and return the following form to Manhattanville College.

Check one box and sign below.

I HAVE (FOR STUDENTS UNDER AGE OF 18, MY CHILD HAS):

had meningococcal immunization within the past 5 years. The vaccine record is attached.

Note: The Advisory Committee of Immunization Practices recommends that all first-year college students up to age 21 years should have at least 1 dose of Meningococcal ACWY vaccine not more than 5 years before enrollment, preferably on or after their 16th birthday, and that young adults ages 16 through 23 years may choose to receive the Meningococcal B vaccine series. College and university students should discuss the Meningococcal B vaccine with a healthcare provider.]

read, or have had explained to me, the information regarding meningococcal disease. I understand the risks of not receiving the vaccine. I have decided that I (my child) will not obtain immunization against meningococcal disease.

SIGNED _____ **DATE** _____

(Parent/Guardian if student is a minor)

PRINT STUDENT'S NAME _____ **DOB** _____



Name _____

DOB _____

Part 5 – Notice of Privacy Practices

(to be read and signed by student and parents/guardians)

This notice describes how health information about you may be used and disclosed and how you can get access to it. Please review 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 the 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 for other healthcare provider's treatment to you.

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

HEALTHCARE OPERATION: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the 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 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 death to a family member, your personal representative, or another person responsible for your care. If you are present, then prior to use or disclose, 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, state or local law enforcement officials, the information required for lawful intelligence, counterintelligence, and other national security activities when required to do so by law.

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail message, postcards, email or letter).

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.

RESTRICTIONS: 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 a emergency).

AMENDMENT: You have the right to request that we amend your health information. Your 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 the medical information to treat me and arrange for medical care, to seek and receive payment for the services provided to me and for the business operation for the Manhattanville College Student Health Center.

Name: _____ Date: _____

Student Signature: _____

Parent Signature: _____

(If student is under 18 years old)



Name _____

DOB _____

Meningococcal Disease

WHAT IS MENINGOCOCCAL DISEASE?

Meningococcal disease is caused by bacteria called *Neisseria meningitidis*. It can lead to serious blood infections. When the linings of the brain and spinal cord become infected, it is called meningitis. The disease strikes quickly and can have serious complications, including death.

Anyone can get meningococcal disease. Some people are at higher risk. This disease occurs more often in people who are:

- Teenagers or young adults
- Infants younger than one year of age
- Living in crowded settings, such as college dormitories or military barracks
- Traveling to areas outside of the United States, such as the “meningitis belt” in Africa
- Living with a damaged spleen or no spleen or have sickle cell disease
- Being treated with the medication Soliris® or who have complement component deficiency (an inherited immune disorder)
- Exposed during an outbreak
- Working with meningococcal bacteria in a laboratory

WHAT ARE THE SYMPTOMS?

Symptoms appear suddenly — usually 3 to 4 days after a person is infected. It can take up to 10 days to develop symptoms.

Symptoms may include:

- A sudden high fever
- Headache
- Stiff neck (meningitis)
- Nausea and vomiting
- Red-purple skin rash
- Weakness and feeling very ill
- Eyes sensitive to light

HOW IS MENINGOCOCCAL DISEASE SPREAD?

It spreads from person to person by coughing or coming into close or lengthy contact with someone who is sick or who carries the bacteria. Contact includes kissing, sharing drinks, or living together. Up to one in 10 people carry meningococcal bacteria in their nose or throat without getting sick.

IS THERE TREATMENT?

Early diagnosis of meningococcal disease is very important. If it is caught early, meningococcal disease can be treated with antibiotics. But sometimes the infection has caused too much damage for antibiotics to prevent death or serious long-term problems. Most people need to be cared for in a hospital due to serious, life-threatening infections.



WHAT ARE THE COMPLICATIONS?

Ten to fifteen percent of those who get meningococcal disease die. Among survivors, as many as one in five will have permanent disabilities. Complications include:

- Hearing loss
- Brain damage
- Kidney damage
- Limb amputations

WHAT SHOULD I DO IF I OR SOMEONE I LOVE IS EXPOSED?

If you are in close contact with a person with meningococcal disease, talk with your healthcare provider about the risk to you and your family. They can prescribe an antibiotic to prevent the disease.

WHAT IS THE BEST WAY TO PREVENT MENINGOCOCCAL DISEASE?

The single best way to prevent this disease is to be vaccinated. Vaccines are available for people 6 weeks of age and older. Various vaccines offer protection against the five major strains of bacteria that cause meningococcal disease

- All teenagers should receive two doses of vaccine against strains A, C, W, and Y, also known as MenACWY or MCV4 vaccine. The first dose is given at 1 to 12 years of age, and the second dose (booster) at 16 years.
 - It is very important that teens receive the booster dose at age 16 years in order to protect them through the years when they are at greatest risk of meningococcal disease.
- Teens and young adults can also be vaccinated against the “B” strain, also known as MenB vaccine. Talk to your healthcare provider about whether they recommend vaccine against the “B” strain.
- Others who should receive meningococcal vaccines include:
 - Infants, children, and adults with certain medical conditions
 - People exposed during an outbreak
 - Travelers to the “meningitis belt” of sub-Saharan Africa
 - Military recruits
- Please speak with your healthcare provider if you may be at increased risk.

WHO SHOULD NOT BE VACCINATED?

Some people should not get meningococcal vaccine or they should wait.

- Tell your doctor if you have any severe allergies. Anyone who has ever had a severe allergic reaction to a previous dose of meningococcal vaccine should not get another dose of the vaccine.
- Anyone who has a severe allergy to any component in the vaccine should not get the vaccine.
- Anyone who is moderately or severely ill at the time the shot is scheduled should probably wait until they are better. People with a mild illness can usually get the vaccine.

WHAT ARE THE MENINGOCOCCAL VACCINE REQUIREMENTS FOR SCHOOL ATTENDANCE?

For grades 7 through 9 in school year 2018–19: one dose of MenACWY vaccine. With each new school year, this requirement will move up a grade until students in grades 7 through 11 will all be required to have one dose of MenACWY vaccine to attend school:

- 2019–20: grades 7, 8, 9, and 10
- 2020–21: and later years: grades 7, 8, 9, 10, and 11

For grade 12: two doses of MenACWY vaccine:

- The second dose needs to be given on or after the 16th birthday.
- Teens who received their first dose on or after their 16th birthday do not need another dose