Dear Student:

Welcome to the Manhattanville College Student Health Center. We offer primary medical care, women’s health services, and referrals to specialty health care to full-time undergraduate students. Health services provided by our physicians and nurses are free of charge to students. However, there may be modest charges for immunizations, meningitis vaccines, certain tests, treatments, or medications. Please note that these charges are well below outside costs.

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 good medical record enables better health service and health guidance for students. 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
 WE REQUIRE THAT THE FOLLOWING BE ON FILE IN THE STUDENT HEALTH CENTER.

Part 1 Student Health Form – Health History Section
This is for you to fill out and sign. Having your medical information in our records will help us to give you the best medical care possible.

If you have a prior history of a chronic or significant medical or psychiatric condition, make sure a copy of these records with a medical summary is sent to the Student Health Center. Your private doctor should send a complete medical summary with accompanying lab and test results. This assures that we can continue to give you the highest quality care.

Part 2 Student Health Form – Physical Exam Section
This is for your health practitioner (medical doctor or nurse practitioner) to fill out, sign and stamp. This includes:

- A PPD or Tuberculosis (T.B.) test or a report of a chest x-ray within the past 12 months. If the T.B. test is positive, a report of the chest x-ray is required.

- Immunization Record – The New York State Health Department requires documentation of immunity for measles, mumps, and rubella. It also highly recommends immunization against meningitis.

- Failure to provide documentation of MMR immunization can result in a fine of $2,000 from the Westchester County Health Department payable by the student and/or parents. Without documentation, students will not be allowed to attend class or reside in the residence halls.

The names of any medication, including birth control pills, which have been prescribed. Manhattanville College cannot assume responsibility or liability for students who are taking medication for the control of any medical or psychiatric condition. 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.

Please note: if you are on any Manhattanville athletic teams, a copy of your physical examination will be sent to your athletic medical chart with your signed consent on the health form.

- Student Demographics/Health Insurance
  For you and your parents/guardian to fill out.

- Consent for Medical Treatment
  For your parents/guardian to sign if you are under 18 years old.

- Meningitis Vaccine
  For you and your parents/guardian to read and fill out.

- Notice of Privacy Practice
  For you and your parents/guardian to read and sign.
Student Health Form

Class Entering

- Freshman
- Sophomore
- Junior
- Senior
- Male
- Female
- Full time
- Part time

Student’s name ___________________________________________ Date _________ / _______ / _______

Address

Social Security Number - - - - - Date of birth _________ / _______ / _______

Local telephone ( ) _______________________________

Expected year of graduation

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 ( )

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

Address

Policy/ID# ___________________________________________ Group Name and #

Subscriber’s name and address

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.

Parent/Guardian Signature ___________________________ Date _________ / _______ / _______

Manhattanville College

Student Health Form
Part 1 Student Health Form  Health History Section

Medical History
Do you have now or have you ever had: (check all that apply)

1. [ ] Acne  11. [ ] Deaf/Hearing Impairment  20. [ ] Impaired Mobility/Paralysis  29. [ ] Pneumothorax
4. [ ] Appendectomy  14. [ ] Emotional/Mental Illness  23. [ ] Learning Disability  32. [ ] Sickle Cell Disease
5. [ ] Arthritis  15. [ ] Heart Disease/Problem  24. [ ] Malaria  33. [ ] Thyroid
6. [ ] Asthma  16. [ ] Hepatitis (Type___)  25. [ ] Migraines/Chronic Headaches  34. [ ] TB/tuberculosis
8. [ ] Cancer/Malignancy  18. [ ] High Cholesterol  27. [ ] Neuromuscular Disease  36. [ ] UTIs(Frequent/Recurrent)
10. [ ] Colitis/Ileitis

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

<table>
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<tr>
<th></th>
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<td>Kidney Disease</td>
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<td>Neuromuscular Disorder</td>
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<td>Cancer</td>
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<td>Mental Illness</td>
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<td>Diabetes</td>
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<td>Stroke</td>
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<td>Heart Disease</td>
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<td>Tuberculosis</td>
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<td>High Cholesterol</td>
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<td></td>
<td>Other Serious Illness</td>
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Health Habits

1. Do you currently smoke cigarettes?  [ ] No  [ ] Yes
   If yes, how many each day? ________ cigarettes/day  Are you thinking of quitting?  [ ] No  [ ] Yes

2. Do you exercise regularly?  [ ] No  [ ] Yes
   If yes, what type? ____________________________________________________________________________

3. Do you drink alcohol?  [ ] No  [ ] Yes

4. On any occasion during the past three months, have you had more than four alcoholic drinks at one sitting?
   [ ] No  [ ] Yes

5. Do you use marijuana?  [ ] No  [ ] Yes

6. Have you used narcotics, stimulants, cocaine, LSD, or other street drugs?  [ ] No  [ ] Yes

7. Do you ever use tranquilizers or sleeping pills?  [ ] No  [ ] Yes

Name _________________________________________________________________________________________

Please explain all positive answers (with dates):
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
Mental Health Issues

1. Do you have any questions or concerns regarding any of the following?
   - Family alcoholism or drug abuse  □ No □ Yes
   - Rape, sexual abuse, or unwanted sexual activity  □ No □ Yes
   - Physical abuse  □ No □ Yes
   - Dating or domestic violence  □ No □ Yes
   - Death of a loved one within the past 12 months  □ No □ Yes

2. Do you feel depressed?  □ Always □ Sometimes □ Never

3. Do you have difficulty controlling your temper?  □ Always □ Sometimes □ Never

4. Do you have any mental health issues?  □ No □ Yes
   - If yes, what kind? __________________________________________________________________________
   - Present or past medications prescribed for this condition __________________________________________________________________________

Women's Health*

Menstrual history

1. Age when you had your first period: __________ years old.
   - Are your periods regular?  □ No □ Yes  Periods come every __________ days. Periods last for __________ days.

2. When did your last period begin? ____/____/____

3. Do you have moderate to severe cramping?  □ No □ Yes

4. Do you take medication for cramps?  □ No □ Yes

5. Have you ever had excessive menstrual bleeding?  □ No □ Yes

6. Do you have significant problems with premenstrual syndrome (PMS)?  □ No □ Yes
   - If yes, symptoms: ______________________________________________________________________

7. Have you had unprotected sex with a male partner since your last menstrual period?  □ No □ Yes

Gynecological health

1. Have you ever had a Pap Smear or pelvic exam?  □ No □ Yes □ Unsure  Date _______ / _______ / _______
   - Was it normal?  □ No □ Yes □ Unsure

2. Do you check your breasts monthly for lumps or discharge?  □ No □ Yes

Men's Health*

1. Do you have any penile discharge or change in urination?  □ No □ Yes

2. Have you ever had undescended testicles?  □ No □ Yes

3. Do you regularly examine your testicles for swelling or lumps?  □ No □ Yes

*Please answer the section that is relevant to you.
Part 2 Student Health Form Physical Exam Section

To the student: Please fill in your name, date of birth, and health history form prior to your physical. Parents who are physicians may neither perform the physical nor sign the physical form.

Name: ___________________________ Date of birth ________ / ________ / ________

Are you on any Manhattanville College athletic team(s)? □ Yes □ No
If yes, please list ___________________________

Medical documentation of sickle cell trait test is attached? □ Yes □ No

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.

______________________________________________ Date

General Medical

1. List physical and psychiatric diagnoses. *Note: If severe chronic condition, please include a medical summary.*

________________________________________________________________________

2. List ALL ongoing prescription medications currently used (include psychiatric medications and birth-control pills).

________________________________________________________________________

3. List ALL other medications taken (vitamins, over-the-counter preparations, herbs, homeopathic medications, food supplements).

________________________________________________________________________

4. List recent hospitalizations (medical/surgical/psychiatric).

________________________________________________________________________

5. Allergies to any medication? □ No □ Yes
If yes, please list ___________________________

6. Any other allergies? □ No □ Yes
If yes, please list ___________________________

7. Is there a loss or serious impairment of any organ or functions? □ No □ Yes
If yes, please list ___________________________

8. Does the student use any assistive devices? □ No □ Yes
If yes, please list ___________________________
New York State Department of Health 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 acceptable. Results of PPD (Tuberculin skin test) is also required.

MMR 2 doses required on or after 1st birthday.
- 1st dose ________ /________/ ________
- 2nd dose ________ /________/ ________
- Immune by titer ________ /________/ ________

OR

Measles 2 doses required on or after 1st birthday.
- 1st dose ________ /________/ ________
- 2nd dose ________ /________/ ________
- Immune by titer ________ /________/ ________

Mumps 2 doses required on or after 1st birthday.
- 1st dose ________ /________/ ________
- 2nd dose ________ /________/ ________
- Immune by titer ________ /________/ ________

Rubella 1 dose required on or after 1st birthday.
- ________ /________/ ________
- Immune by titer ________ /________/ ________

Please submit lab reports

Required Tests (must be dated within 1 year of enrollment)

PPD _______ mm induration CXR (required if PPD is positive)
Date planted______/______/______ Results □ Normal □ Abnormal
Date read______/______/______ Date______/______/______
Received INH? □ No □ Yes Date INH completed _______ /_____/______

Recommended Immunizations/Tests

Tetanus
- Had basic series (3)? □ No □ Yes
- Date of last booster_____ /_____/______

Polio □ IPV □ OPV □ Hemoglobin
- Had basic series (3)? □ No □ Yes
- Date of last booster_____ /_____/______

Hepatitis B
- Not vaccinated □ 1 dose
- 2 doses
- 3 doses
- Date last dose______/______/______

Varicella (chicken pox)
- Not vaccinated □ 1 dose
- 2 doses
- Had disease
- Date last dose/titer______/______/______

Sickle cell
- Not tested
- Tested positive trait □ Tested negative trait
- Has disease
- Date tested______/_____/______

Meningococcal vaccination
- Date ________ /_____/______ □ Not vaccinated

Physician’s signature (required ____________________________ Stamp:
Physicians’s printed name: ____________________________ Phone (______) __________________
Address: ____________________________
# Physical Exam (must be performed within 1 year prior to enrollment)

Student's name: 

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General appearance: 

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Is the student medically cleared for participation in athletics?  □ Yes □ No

If no, please explain: 

Date of exam (must be within the past 12 months) _____/_____/______

Physician's signature (required) ___________________________ STAMP:

Physician’s printed name______________________________ Phone (_____) __________________

Address__________________________________________________________________________
______________________________________________________________________________
Meningitis Vaccine

New York State Public Health Law requires that all colleges and university students enrolled for at least 6 hours or credits per semester, or 4 hours per quarter, to complete this form. Once completed, please return the following form to Manhattanville College Student Health Center.

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 the information regarding meningococcal meningitis disease explained. I (the student) will obtain immunization against meningococcal meningitis within 30 days from a private health care provider or from the Manhattanville College Student Health Center.

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

__________________________________________
Student signature

__________________________________________
Parent/Guardian signature (if student is under 18 years old)
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 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. 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 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)