

INSTRUCTIONS REGARDING HEALTH INFORMATION

Completion of these forms is required of all new students. You cannot register until these forms are received.

PLEASE TAKE HEALTH FORMS PACKET TO VISIT WITH PROVIDER.

Health Information Form

You must complete these sections regarding your medical history. Your physician or health care provider must comment on any medical history elements entered here.

Immunization Records

Your physician or health care provider must document the following immunizations:

IMMUNIZATION REQUIREMENTS

1. Measles: two doses
 - (a) the first after age 12 months, and after 1968
 - (b) the second after January 1, 1980

Please note that Connecticut state law requires all entering students (undergraduate and graduate) born after Jan 1, 1957 to have documented evidence of having received 2 doses of measles, as outlined above. Documentation that you had measles by blood test (titer) can be submitted by your physician.

2. Rubella (German measles): at least one dose after age 12 months
3. Mumps: vaccine after 12 months of age
4. or MMR (measles, mumps, rubella) compliant with the above dates
5. TB skin test (Mantoux): see health information form under immunizations.
6. Tetanus-diphtheria (Td or Tdap): booster within 10 years
7. Meningitis: Connecticut law requires that each undergraduate student who resides in on-campus housing be vaccinated against meningitis as a condition of residence.

Physical Exam Form

A physical exam performed by a non-family member is required.

GRADUATE STUDENTS ARE NOT REQUIRED TO HAVE A PHYSICAL EXAMINATION.

THESE FORMS SHOULD BE COMPLETED AND RETURNED BY July 15, 2008.

Your complete health information form must be on file at Davison Health Center before you will be allowed to register for any classes

QUESTIONS: If you foresee problems with immunizations or completion of these records, please write, email, or call Ms. Schukoske.

Ms. Martha Schukoske, Office Manager
Wesleyan Health Center
327 High Street
Middletown, CT 06459
(860) 685-2470 – mschukoske@wesleyan.edu

Allergy Medications:

If you wish to receive allergy immunotherapy at Davison Health Center, please download the form at www.wesleyan.edu/healthservices/geninfo/forms/allergypacket.pdf, review it, and have it completed by your allergist. We cannot administer any immunotherapy until this form is in your record.



**PERSONAL AND
CONFIDENTIAL**

Wesleyan University Health Center
327 High Street
Middletown, CT 06459
Phone: (860) 685-2470 Fax (860) 685-2471 TDD (860) 685-4788

STUDENT HEALTH FORM

PLEASE PRINT OR TYPE

Student's Legal Name: _____ Preferred Name: _____

Birthdate: _____ Gender: _____ SSN: _____

Permanent Home Address: _____

Telephone: _____ Class Year: _____ Country of Birth: _____

Parent 1/Guardian 1-full name and address: _____

Parent 2/Guardian 2-full name and address: _____

In case of emergency, notify:

Full name	Relationship
Address	Telephone

AUTHORIZATION FOR TREATMENT

I certify to the best of my knowledge that the information on this form is complete and correct, and I give my consent to share medical information with hospital or emergency medical personnel in the case of an emergency. I hereby authorize the Wesleyan University Health Center staff to provide medical treatment and services, as they deem appropriate. This authorization will remain in effect as long as I am a student at Wesleyan University. I also certify that I have downloaded from the Health Service web page, or received by mail, the "Notice of Privacy Practice form".

In the event of serious illness or injury, parent(s) or guardian(s) may be notified at the discretion of the professional staff.

Student Signature	Date
Parent or Guardian Signature (for students under 18 years of age)	Date

Medical/Health History - Student Name: _____
Provider Review (Initials): _____

Have you ever had or do you now have any of the following? Explain YES answers in the space below or use a separate sheet

Check each item	Y	N	Check each item	Y	N	Check each item	Y	N
INFECTIOUS DISEASES			DIGESTIVE			EMOTIONAL HEALTH		
Mononucleosis			Ulcers			ADHD		
Chicken Pox			Hepatitis			Excessive nervousness		
Rheumatic Fever			Gallstones			Recurrent anxiety		
Tuberculosis or positive skin test			Irritable Bowel syndrome			Panic attacks		
Malaria			Inflam. Bowel Disease			Recurrent depression		
Pertussis (Whooping cough)						Bipolar disorder		
Meningitis			URINARY					
HIV/AIDS			Bladder infection			NUTRITION ISSUES		
			Kidney infection			Special dietary needs		
HEAD/NERVOUS SYSTEM			Kidney stone			Eating disorder		
Concussion/head injury						Obesity		
Migraine			BONES/JOINTS					
Insomnia			Painful or swollen joint(s)			HABITS		
Seizures/convulsions			Back problems			Alcohol		
Color blind			Arthritis			Tobacco, # cigarettes/ day		
Blindness			Recent fracture(s)			Chewing tobacco/snuff		
Hearing impairment			Chronic pain			Drugs		
Neuromuscular disorder			Joint Injury			Anabolic steroids		
EYE EAR NOSE THROAT			SKIN			ALLERGY		
Glasses			Acne			Hives		
Contact lenses			Other skin disease			Food allergy (list below)		
Frequent ear infections						Insect stings/bites (list below)		
Sinus problems			BLOOD			Medications (list below)		
Tonsils/adenoids removed			Anemia			Need for allergy shots		
			Sickle trait or disease					
ENDOCRINE SYSTEM						OTHER		
Diabetes			GYNECOLOGIC			Cancer		
Thyroid Disease			Gyn exam			Serious illness		
Polycystic ovary syndrome			Irregular menstrual periods			Serious injury/accident		
			Gynecological disorder					
HEART LUNGS			Hormonal contraceptives			SPECIAL NEEDS /DISABILITY		
Heart murmur			Do you do a breast self-exam?					
High blood pressure			Breast lumps					
Irregular/rapid heartbeat								
High Cholesterol			UROLOGIC					
Asthma			Undescended testicle					
Pneumonia			Testicular cancer					
			Inguinal hernia					
			Do you do testicular self-exam?					

Please comment on any active/significant medical issues. For concussions, please list dates.
 If you have a current complex medical problem that will require ongoing care, please have your physician attach a letter of explanation.

Please list any current medications. Include prescriptions, over-the-counter medicines, herbal supplements, and birth control.

Allergic to - Medications _____ Epipen Yes No (circle)
 Foods _____ Epipen Yes No (circle)
 Insects/Other _____ Epipen Yes No (circle)

Family history of serious illness (mother, father, siblings) _____

Previous hospitalization (include year) _____
 Previous surgery (include year) _____

Please complete the TB screening questionnaire on page 5 of this form.

Provider:

Please complete the Immunization and Medical Examination Form. (Includes cardiovascular screening for all students). Please review and comment on any items checked in History section.

MEDICAL EXAMINATION REQUIRED WITHIN TWELVE MONTHS OF REGISTRATION. (*Must be completed by other than family member.*)

IMMUNIZATION HISTORY

Student Name _____ Date of Birth _____

Minimum requirements:

Measles vaccine- two doses, the first after age 12 months (and after 1968), and the second after January 1, 1980

Rubella vaccine –one dose after age 12 months

Meningitis vaccination – one dose

Connecticut law requires proof of immunity against measles and rubella **or** demonstrated immunity by laboratory (titer) evidence before registration. If vaccine dates are not available, you must provide a copy of a lab titer report proving immunity.

Connecticut law requires that each undergraduate student who resides in on-campus housing be vaccinated against meningitis as a condition of residency. Exemptions: Those who submit documentation from a personal physician stating medical reasons why vaccination should not be done, or those with religious beliefs against immunization.

PLEASE LIST ALL DATES

	1	2	3	Boosters
VACCINE:	Dates	Dates	Dates	Dates
MMR <i>REQUIRED or</i>				
Measles <i>REQUIRED</i>				
Mumps				
Rubella <i>REQUIRED</i>				
Meningococcal <i>REQUIRED</i>				
DPT				
Tdap				
Td (Adult Tetanus)				
Polio (oral or IPV)				
Varicella/Chicken Pox (2 DOSES <i>RECOMMENDED</i>)				
Hepatitis B <i>RECOMMENDED</i>				
HPV				
Other				

Student Name: _____

TUBERCULOSIS SCREENING QUESTIONNAIRE AND TESTING REQUIREMENTS

1. Have you ever had a positive TB (ppd/Mantoux)? Yes/No (circle one)
If yes, Chest X-Ray, date _____ Chest X-Ray results _____
2. Have you ever been in close contact with a person with TB? Yes/No (circle one)
3. Were you born in one of the countries listed below (circle country)?
4. Have you spent more than one month at a time in one of the countries listed below?
If yes, list countries _____

International Students

Tuberculosis (TB) risk screening is required for international students arriving from countries where TB is endemic (**See list below**). **TB screening and testing will be done at Wesleyan Health Center after your arrival on campus.** Students who have had a positive tuberculin test in the past will not need another test, but should still undergo a brief assessment at the Health Center. International students who have received BCG vaccine are not exempt from the requirements for TB screening and testing.

All Other Students

Providers: Please review the TB risk assessment questions above and place a TB skin test (ppd/Mantoux) **ONLY** if risk factors are present.

Mantoux Tuberculin Skin Test (within 6 months of enrollment): Date planted _____ Date read _____
Results, in mm induration _____ If positive, Chest X-Ray, date _____ Chest X-Ray results _____

COUNTRIES WITH HIGH RATES OF TUBERCULOSIS (TB)*

Afganistan	China	Guyana	Mauritania	Portugal	Tokelau
Algeria	China-Macao SAR	Haiti	Mauritius	Qatar	Tonga
Angola	Columbia	Honduras	Mexico	Romania	Tunisia
Anguilla	Comoros	India	Micronesia	Russian Federation	Turkey
Argentina	Congo	Indonesia	Moldova-Rep.	Rwanda	Turkmenistan
Armenia	Congo DR	Iran	Mongolia	St. Vincent and the Grenadines	Tuvalu
Azerbaijan	Cote d'Ivoire	Iraq	Montenegro	Sao Tome & Principe	Uganda
Bahamas	Croatia	Japan	Morocco	Saudi Arabia	Ukraine
Bahrain	Djibouti	Kazakhstan	Mozambique	Senegal	Uruguay
Bangladesh	Dominican Rep.	Kenya	Myanmar	Seychelles	Uzbekistan
Belarus	Ecuador	Kiribati	Nambia	Sierra Leone	Vanuatu
Belize	Egypt	Korea-DPR	Nauru	Singapore	Venezuela
Benin	El Salvador	Korea-Rep.	Nepal	Solomon Islands	Vietnam
Bhutan	Equatorial Guinea	Kuwait	New Caledonia	Somalia	Wallis and Futuna Is.
Bolivia	Eritrea	Kyrgyzstan	Nicaragua	South Africa	Yemen
Bosnia & Herzegovina	Estonia	Lao PDR	Niger	Spain	Zambia
Botswana	Ethiopia	Latvia	Nigeria	Sri Lanka	Zimbabwe
Brazil	Fiji	Lesotho	Niue	Sudan	
Brunei Darussalam	French Polynesia	Liberia	Northern Mariana Islands	Suriname	
Bulgaria	Gabon	Lithuania	Pakistan	Syrian Arab Rep.	
Burkina Faso	Gambia	TFYR	Palau		
Burundi	Georgia	Madagascar	Panama	Swaziland	
Cambodia	Ghana	Malawi	Papua New Guinea	Tajikistan	
Cameroun	Guam	Malaysia	Paraguay	Tanzania-UR	
Cape Verde	Guatemala	Maldives	Peru	Thailand	
Central African Republic	Guinea	Mali	Philippines	Timor-Leste	
Chad	Guinea-Bissau	Marshall Islands	Poland	Togo	

*World Health Organization, Global tuberculosis control. WHO report 2006.

Physical Exam:**Student Name:** _____
 Height _____ Weight _____ Blood Pressure in sitting position _____ Pulse _____
 BMI _____ If <18.5 or > 30, please comment _____

 Vision without glasses _____ With glasses _____ Hearing Right _____
 Vision Right 20/ _____ Right 20/ _____ Left _____
 Vision Left 20/ _____ Left 20/ _____

Urinalysis: Sp.Gr _____ Glucose _____ Prot _____ Ketones _____ Blood _____ Serum Hgb or Hct _____

SYSTEM	NORMAL	DESCRIBE IF ABNORMAL
Skin		
HEENT		
Lungs, Chest		
Breasts		
Heart/Vascular system (Describe murmur, click etc.)		
Precordial Auscultation in both supine and standing positions to identify murmurs consistent with dynamic left ventricular outflow obstruction		
Assessment of femoral artery pulses to exclude coarctation of the aorta		
Assessment and lack of recognition of physical stigmata of Marfan's Syndrome		
Abdomen, liver, spleen, kidneys		
Genitourinary		
Pelvic, if indicated (pls attach most recent Pap)		
Anorectal		
Lymphatic		
Musculo-skeletal		
Neurological		
Endocrine		
Psychological		

 List all allergies, including medications, insect venom, etc.

EpiPen required? Yes No (circle)

 List all current medications with doses

 Comment on special dietary requirements

 Status of student's health Excellent Good Poor Comments _____

 May participate in the following sports (check one): Contact/Collision Limited Contact NonContact
 Comments _____

 Is this student being treated for chronic/ongoing medical or orthopedic problems? Yes No

If yes, please send a separate letter with pertinent history and ongoing treatment plan/recommendations.

Having examined this applicant and reviewed his or her past medical history, I consider that _____ is fit to attend Wesleyan University. I have received permission from this student and would be willing, if indicated, to discuss issues pertaining to their health status with the professional staff of Davison Health Center and will furnish additional pertinent medical records upon request.

Provider Name _____ Telephone _____

Address _____ Signature _____

Date _____

Davison Health Center Notice of Privacy Practices

This notice describes how your medical information may be used and disclosed and how you can access this information. Please review it carefully.

Davison Health Center must maintain the privacy of your personal health information and give you this notice that describes our legal duties and privacy practices concerning your personal health information. In general, when we release your health information, we must release only the information we need to achieve the purpose of use or disclosure. However, all of your personal health information will be available for release to you, to a provider regarding your treatment, or due to legal requirement. We must follow the privacy practices described in this notice.

However, we reserve the right to change the privacy practices described in this notice, in accordance with the law. Changes to our privacy practices would apply to all health information we maintain. If we change our privacy practices, we will give you a revised copy of the notice by access to our website, www.wesleyan.edu/healthservices/, or by calling the office and requesting a revised copy be sent to you, or receiving a copy at the time of your next appointment.

I. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

Upon entry to the University, you have signed a consent form to authorize Davison Health Center to provide medical treatment if you request it. Once you have signed our consent form, we can use your health information for the following purposes: **Please note that if you refuse to provide consent to us, we may refuse to treat you.**

- A. **Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes coordination or management of your health care with a person or entity which has already obtained your permission to have access to your protected health information. **For example, we would disclose protected health information, with your permission, to another health care provider or sports trainer who may be treating you, to ensure that they have the necessary information to diagnose and treat you.**

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g. specialist or laboratory), who, at the request of your provider, becomes involved in your healthcare by providing assistance with your diagnosis or treatment to your health care provider.

We may also call you by name in the waiting room when your healthcare provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health related benefits and services offered by our office.

- B. **Payment:** **Appointments and visits to Davison Health Center are covered by your regular tuition payments. You do not have to pay extra for general visits. However, certain services provided by the Health Center, such as laboratory testing and prescription medications, may be charged to your student account with your permission. Bills that are submitted to the Office of the Bursar *will not* have specific or protected health information included. The Office of the Bursar will note on your account that you were charged for a "Health Service Fee" with a specific amount.**

Also, if you are referred for services outside of the Health Center for a problem diagnosed at the Health Center, we may release to your insurance company, with your permission, relevant protected health information to assist them in determining your eligibility for coverage and benefits outside of the Health Center and reviewing services provided to you outside of the Health Center for medical necessity.

- C. **Healthcare Operations:** We may use or disclose, as needed, your protected health information in the administrative activities of Davison Health Center. These activities include, but are not limited to: Quality Assurance review activities; Employee review activities; Training of medical residents and nursing students; Licensing of the Health Center and Staff. For example, we may disclose your protected health information to medical residents and nursing students who may see you in the office while doing a training rotation here.

In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign in. We may also call you by name in the waiting room. We may use or disclose your protected health information, as necessary, to contact you to remind you of an appointment.

Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing, except to the extent that the Health Center has already sent out the requested information.

We may use and disclose your protected health information in the following instances. You have the right to agree or object to the use and disclosure of all or part of your protected health information. If you are not able to agree or object to the use or disclosure of protected health information, then your physician, in his/her professional judgment, will determine whether the disclosure is in your best interest. In this case, only the health information that is relevant to your current health problem will be discussed.

- A. Others Involved In Your Healthcare: Unless you object, we may disclose to a member of your family or a close friend or any other person you identify, your protected health information that directly relates to their involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose the information as necessary if we determine that it is in your best interest, based on our professional judgment, to use and disclose your protected health information to notify or assist in notifying a family member, personal friend, or any other person that is responsible for your care, of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family and other individuals involved in your healthcare.

- B. Emergencies: We may use or disclose your protected health information in an emergency treatment. If this happens, your health care provider shall try to obtain your consent as soon as reasonably practicable after the treatment. If your physician or another practitioner in the Health Center is required by law to treat you, and they attempted to obtain your consent but are unable to do so, they may still use your protected health information to treat you.

- C. Communication Barriers: We may use or disclose your protected health information if your physician or another practitioner in the Health Center attempts to obtain consent from you but is unable to do so due to substantial language barriers and the practitioner determines, using professional judgment, that you intend to consent to treatment under the circumstances.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent or Opportunity to Object.

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

- A. Required By Law: We may use or disclose your protected health information to the extent that the use is required by law. The use or disclosure will be made in compliance with the law, and will be limited to the requirements of the law. For example, we may have to report abuse, neglect, domestic violence, or certain physical injuries, or respond to a court order. You will be notified, as required by law, of any such uses or disclosures.

- B. Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, as directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

- C. Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading that disease or condition.

- D. Health Oversight: We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information may include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- E. Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance as required.
- F. Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful proceeding.
- G. Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurred on the premises of the practice, and (6) medical emergency (not on the practice premises) where it is likely that a crime has occurred.
- H. Coroners, Funeral Directors and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining the cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaver organ, eye and tissue donations.
- I. Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal, and established protocols to ensure the privacy of your protected health information. For example, such research might help determine whether a certain treatment is effective in curing an illness.
- J. Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.
- K. Military Activity and National Security: When the appropriate conditions apply, we may use or disclose the protected health information of individuals who are Armed Forces personnel (1) for the activities deemed necessary by military command authorities; (2) for the purpose of a determination of eligibility for benefits by the Department of Veteran's Administration, or (3) to a foreign military authority under which you serve as a member. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including the provision of protective services to the President or others legally authorized.
- L. Worker's Compensation: We may use or disclose your protected health information, as authorized, to comply with worker's compensation laws and other similar legally established programs.
- M. Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.
- N. Required Uses and Disclosures: Under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

II. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights:

- A. You have the right to inspect and obtain a copy of your protected health information. This means you may obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A “designated record set” contains medical and billing records and other records that your physician and the practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have the right to have this decision reviewed. Please contact our Privacy Contact, listed at the end of this notice, if you have questions about access to your medical record.

- B. You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care, or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want this restriction of access to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by discussing it with your physician, and then requesting the specific restriction in writing.

- C. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled, or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact, listed below.

- D. You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact listed below if you have any questions about amending your medical record.

- E. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for the purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

- F. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

III. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe we have violated your privacy rights. You may file a complaint with us by notifying our Privacy Contact of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Contact, Joyce Walter at 860-685-2470, or Davison Health Service, 327 High Street, Middletown, CT 06459, for further information about the complaint process or any other questions you have regarding this notice.

This notice is published and becomes effective on April 14, 2003.

**Davison Health Center
327 High Street
Middletown, CT 06459
(860) 685-2470**

Revised 3/08

RECEIPT OF PRIVACY NOTICE

I, _____, have received a copy of the Davison Health Center Notice of Privacy Practices.

Signature

Date

Witness

Date

Office Use Only:

Notice sent via mail per student request. Date: _____ Witness: _____

Notice sent to first-year student with required Health Center material.

OFFICE OF BEHAVIORAL HEALTH FOR STUDENTS HEALTH SURVEY

Information on this form is CONFIDENTIAL. The information you give is used to help provide you with informed quality care should you need it. This form does not become a part of your medical record. The only health professionals who see this are those in the Office of Behavioral Health for Students. This form cannot be released without the student's written consent and the form will not affect admission status.

IDENTIFICATION DATA *[please print]:*

Name: _____

Social Security No.: _____ Date of Birth: _____

Below is a list of problems and complaints that people sometimes have. Read each one carefully and select one of the numbered descriptors that describes THE GREATEST DISCOMFORT THAT PROBLEM HAS CAUSED YOU DURING THE PAST YEAR *INCLUDING TODAY*. Circle that number to the right of the problem.

Example: HOW MUCH WERE YOU DISTRESSED BY		<i>Answer</i>				
	Body Aches	0	1	2	3	4
Descriptors:						
	0 - Not at all	1 - A little bit	2 - Moderately	3 - Quite a bit	4 - Extremely	
1.	Repeated unpleasant thoughts	0	1	2	3	4
2.	Thoughts of ending your life	0	1	2	3	4
3.	Anger outbursts that you could not control when alone or with others	0	1	2	3	4
4.	Worrying too much about things	0	1	2	3	4
5.	Feeling hopeless about the future	0	1	2	3	4
6.	Thoughts of death or dying	0	1	2	3	4
7.	Having urges to beat, injure, or harm someone	0	1	2	3	4
8.	Feelings of worthlessness.....	0	1	2	3	4
9.	Having thoughts about sex that bother you a lot	0	1	2	3	4
10.	Thoughts and images of a frightening nature	0	1	2	3	4
11.	Never feeling close to another person	0	1	2	3	4
12.	Feelings of guilt—always blaming yourself for things	0	1	2	3	4
13.	Worrying about family problems	0	1	2	3	4
14.	Concerns about your drug or alcohol use	0	1	2	3	4

A. Have you experienced the death of a family member, friend, etc., recently? Yes No
If yes, your relationship to that person(s) _____

B. Have you had psychotherapy previously? Yes No
If yes, dates (approx. month(s) and year(s)): _____
Problem areas then (optional) _____

C. Have you ever been hospitalized for the treatment of an emotional problem? Yes No
If yes, when and for how long? _____

D. Are you currently taking any prescribed medication for mental health problems? Yes No
If yes, list: _____

E. Do you feel you have a problem with any of the following? (Please check as many as apply):
 excessive dieting compulsive eating binge purging use of laxatives
 vomiting excessive exercising body image

F. Have you ever made a suicide attempt? Yes No
If yes, at what age and how: _____

G. Has anyone in your family (immediate or extended) ever committed suicide? Yes No
If yes, when and how, and your relationship to that person: _____

H. Have any of your friends committed suicide? Yes No
If yes, when and how? _____

I. Have you ever done something deliberately self-destructive? Yes No
If yes, briefly describe: _____

J. Have you ever at any time experienced extreme anxiety or panic attacks? If yes, at what age?
 Yes No