

INSTRUCTIONS REGARDING HEALTH INFORMATION

Completion of these forms is required of all new students including transfers. A hold may be placed on class registration if forms are not received in a timely manner.

PLEASE TAKE HEALTH FORMS PACKET TO VISIT WITH YOUR 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 here.

Immunization Records

Please note that Connecticut state law requires that all full-time and matriculating students (undergraduate and graduate) born after December 31, 1956, provide proof of adequate immunization against measles, mumps, rubella and varicella as recommended by the Advisory Committee of Immunization Practices (ACIP) prior to student enrollment at the university.

- 1) Proof of immunity to Measles (Rubeola), Mumps and Rubella (German Measles) - please provide proof of one of the following if born after December 31, 1956:
 - a) Two measles, mumps, rubella (or MMR) immunizations (first after age 12 months; the second dose at least 28d after dose #1)
 - b) Documentation of positive measles, mumps and rubella titers (blood test), OR
 - c) Documentation of date of measles, mumps or rubella disease **by your health care provider**

- 2) Proof of immunity to Chicken Pox (Varicella) – please provide proof of one of the following if born after January 1, 1980:
 - a) Two varicella immunizations (first after age 12 months; the second dose at least 28d after dose #1), OR
 - b) Documentation of positive varicella titer (blood test), OR
 - c) Documentation of date of varicella disease **by your health care provider**

- 3) Proof of Meningococcal immunization
 - a) **Connecticut state law requires that all full-time and matriculating students who reside in on-campus housing be vaccinated against meningitis and submit evidence of having received a meningococcal conjugate vaccine not more than five years prior to enrollment.**
 - b) The Wesleyan University requires evidence of having received a meningococcal vaccine that covers the strains A, C, Y, and W-135. Acceptable MCV4 (quadravalent) vaccines are Menactra®, Menveo®, Mencevax®; or others as long as they cover all 4 specified strains. Immunization with MPSV4 (e.g., Menomune) more than 5 years ago should be updated with MCV4. **Vaccination with monovalent or bivalent strains will not be accepted.**
 - c) Please note that in October 2010 the Advisory Committee on Immunization Practices is now recommending booster doses of the MCV4 vaccine for healthy adolescents 16-18 years of age. **If it has been greater than 5 years since your last immunization, please speak to your medical provider about getting a booster shot.**

- 4) Proof of screening for **Tuberculosis (TB)** is required of all students. **Domestic students** need to complete the “Tuberculosis Screening Questionnaire and Testing” that is part of the health history form (see page 6). Domestic students who answer “yes” to any questions, will need to have a TB test if deemed appropriate by your healthcare provider.
Acceptable TB tests include:
 - a) Mantoux (PPD) skin test or
 - b) Quantiferon Gold or T-Spot blood testsIf your TB test is positive, or if you have had a positive TB test in the past, you will need a chest x-ray. We accept chest x-rays completed within the **past 6 months**. The radiology report **must** be attached in order for the university to accept the x-ray results.

Tuberculosis (TB) risk screening is also required of **international students** entering from countries where TB is endemic (see list page 6 on the medical health forms). **TB screening and testing will be done at Wesleyan Health Center after your arrival on campus.**

International students who have received BCG immunization are not exempt from the requirements for TB screening and testing.

- 5) Proof of Tetanus-diphtheria vaccination recommended

Physical Exam Form

A physical exam performed by a non-family member is required and must be within a **two year period** from matriculation. GRADUATE STUDENTS ARE **NOT** REQUIRED TO HAVE A PHYSICAL EXAMINATION.

THESE FORMS SHOULD BE COMPLETED AND RETURNED BY January 15, 2020.

Your complete health information form must be on file at Davison health Center before you will be allowed to register for classes. In order to avoid delays, please see your healthcare provider as soon as possible, particularly if your immunization records are incomplete, so that you may obtain any required immunizations/titers. **You may mail, fax or scan your completed forms to dropbox at:**

https://webapps.wesleyan.edu/dropbox/health_services

QUESTIONS: If you foresee problems with immunizations or completion of these records, please email healthforms@wesleyan.edu .

Rhonda Radcliff, Medical Office Manager
Wesleyan Health Center
327 High Street
Middletown, CT 06459
(860) 685-2470 – phone
(860) 685-2471 - fax
healthforms@wesleyan.edu

Allergy Medications

If you wish to receive allergy immunotherapy at Davison Health Center, please download the form at www.wesleyan.edu/healthservices/office/allergypacket2.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

STUDENT HEALTH FORM

PLEASE PRINT OR TYPE

Student's Legal Name: _____ Preferred Name: _____

Birthdate: _____ Gender: _____

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
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Address	Telephone
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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
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Parent or Guardian Signature (for students under 18 years of age)	Date
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Hold will be placed on your student account until this form is completed.

Due: January 15, 2020

**Wesleyan University Health Services Vaccination Record
Vaccination Record for incoming/transfer students Spring '20**

Return to:
Wesleyan University
Davison Health Center
327 High Street
Middletown, CT 06459 USA
P (860)685-2470 F (860)685-2471

Undergraduate Student Graduate Student, Department or School _____

Last Name	First Name	Date of Birth _____ Month Day Year
E-mail	Phone	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender

Questions? Visit our Frequently Asked Questions (FAQ's): www.wesleyan.edu/healthservices or e-mail us healthforms@wesleyan.edu

REQUIRED VACCINATIONS

Measles, Mumps, Rubella (MMR) MMR - combined	2 doses or a positive titer. Dose #1 on or after 1 st birthday (and after 12/31/1956). Dose #2 ≥ 28 days after dose #1.	Dose #1 ____/____/____ Month Day Year	Dose #2 ____/____/____ Month Day Year	<input type="checkbox"/> Titers attached
Or				
If single vaccines	2 doses of measles vaccine or a positive titer. Dose #2 ≥ 28 days after dose #1.	Dose #1 ____/____/____ Month Day Year	Dose #2 ____/____/____ Month Day Year	<input type="checkbox"/> Titer attached
	2 doses of mumps vaccine or a positive titer. Dose #2 ≥ 28 days after dose #1.	Dose #1 ____/____/____ Month Day Year	Dose #2 ____/____/____ Month Day Year	<input type="checkbox"/> Titer attached
	2 doses of rubella vaccine or a positive titer. Dose #2 ≥ 28 days after dose #1.	Dose #1 ____/____/____ Month Day Year	Dose #2 ____/____/____ Month Day Year	<input type="checkbox"/> Titer attached
Meningococcal (conjugate required) (on or after 1/2014)	Select type: Must cover strains A,C,Y, W-135 <input type="checkbox"/> Menactra® <input type="checkbox"/> Menveo® <input type="checkbox"/> Nimerex® <input type="checkbox"/> Mencevax® <input type="checkbox"/> Other _____ 1-2 doses. Only 1 if administered ≥ age 16.	Dose #1 ____/____/____ Month Day Year	Dose #2 ____/____/____ Month Day Year	
Varicella Vaccine (Chicken Pox)	2 doses, date of clinician's diagnosis or positive titer. Dose #1 on or after 1 st birthday. Dose #2 ≥ 28 days after dose #1.	Dose #1 ____/____/____ Month Day Year	Dose #2 ____/____/____ Month Day Year	Clinician's Diagnosis ____/____/____ Month Day Year <input type="checkbox"/> Titer attached

RECOMMENDED VACCINATIONS

Diphtheria, Tetanus, Pertussis	Series of 5 doses	Dose #1 ____/____/____ Month Day Year	Dose #2 ____/____/____ Month Day Year	Dose #3 ____/____/____ Month Day Year	Dose #4 ____/____/____ Month Day Year	Dose #5 ____/____/____ Month Day Year
Adult Tetanus, Diphtheria, Pertussis	1 dose within 10 years Select type: <input type="checkbox"/> Td <input type="checkbox"/> Tdap <i>(preferred)</i>	____/____/____ Month Day Year				
Hepatitis A Vaccine	Series of 2 doses	Dose #1 ____/____/____ Month Day Year	Dose #2 ____/____/____ Month Day Year			
Hepatitis B Vaccine	Series of 3 doses	Dose #1 ____/____/____ Month Day Year	Dose #2 ____/____/____ Month Day Year	Dose #3 ____/____/____ Month Day Year		<input type="checkbox"/> Titer attached
Hib Vaccine (Haemophilus influenzae type b)	Series of 4 doses	Dose #1 ____/____/____ Month Day Year	Dose #2 ____/____/____ Month Day Year	Dose #3 ____/____/____ Month Day Year	Dose #4 ____/____/____ Month Day Year	
HPV Vaccine (human papillomavirus)	Series of 3 doses	Dose #1 ____/____/____ Month Day Year	Dose #2 ____/____/____ Month Day Year	Dose #3 ____/____/____ Month Day Year		
Polio Vaccine	Select type: <input type="checkbox"/> OPV <input type="checkbox"/> IPV	Dose #1 ____/____/____ Month Day Year	Dose #2 ____/____/____ Month Day Year	Dose #3 ____/____/____ Month Day Year	Dose #4 ____/____/____ Month Day Year	
Meningitis B	Circle type: Bexsero (series of 2 doses) OR Trumenba (series of 3 doses)	Dose #1 ____/____/____ Month Day Year	Dose #2 ____/____/____ Month Day Year	Dose #2 ____/____/____ Month Day Year		

Clinician Signature	Telephone	Date
Address	Fax	

Student is compliant with the above requirements. See attached record.

Wesleyan University Health Services TB Screening Form

327 High Street, Middletown, CT 06459 Phone: 860-685-2470
Please Fax: (860) 685-2471 or Email forms: healthforms@wesleyan.edu

PRINT LAST NAME _____ FIRST NAME _____ DATE OF BIRTH _____

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 may not need another test, but will 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.**

Domestic Students

Please complete the questionnaire below. If you answer NO to all questions, no further action is required. **If you answer YES to any questions below, your Healthcare Provider is asked to follow up with appropriate testing, when indicated, and to attach chest x-ray results obtained within 6 months of admission to Wesleyan for all students with a history of a positive TB Test.**

PART II. TUBERCULOSIS SCREENING QUESTIONNAIRE AND TESTING REQUIREMENTS (Questions 1-4 to be answered by the student)							
1. Have you ever had a positive tuberculosis skin or blood test? If yes, provider is asked to complete chest x-ray and medication treatment sections below.					<input type="checkbox"/> Yes <input type="checkbox"/> No		
2. Have you ever been in close contact with a person with active tuberculosis (TB)?					<input type="checkbox"/> Yes <input type="checkbox"/> No		
3. Were you born in one of the countries listed below? If yes, please circle country below.					<input type="checkbox"/> Yes <input type="checkbox"/> No		
4. Have you ever lived or traveled for more than one month at a time in one of the countries below? If yes, circle country below.					<input type="checkbox"/> Yes <input type="checkbox"/> No		
COUNTRIES WITH HIGH RATES OF TUBERCULOSIS (TB)							
Afghanistan	Cameroon	Greenland	Malawi	Panama	Suriname		
Algeria	Central African Rep.	Guam	Malaysia	Papua New Guinea	Swaziland		
Angola	Chad	Guatemala	Maldives	Paraguay	Syrian Arab Republic		
Anguilla	China	Guinea	Mali	Peru	Taiwan		
Argentina	Columbia	Guinea-Bissau	Marshall Islands	Philippines	Tajikistan		
Armenia	Comoros	Guyana	Mauritania	Portugal	Thailand		
Azerbaijan	Congo	Haiti	Mauritius	Qatar	Timor-Leste		
Bahamas	Côte d'Ivoire	Honduras	Mexico	Rep. of Korea	Togo		
Bangladesh	DPR of Korea	India	Micronesia	Rep. of Moldova	Tunisia		
Belarus	DR of the Congo	Indonesia	Mongolia	Romania	Turkmenistan		
Belize	Djibouti	Iraq	Morocco	Russian Federation	Tuvalu		
Benin	Dominican Republic	Kazakhstan	Mozambique	Rwanda	Uganda		
Bhutan	Ecuador	Kenya	Myanmar	Sao Tome & Principe	Ukraine		
Bolivia	El Salvador	Kiribati	Namibia	Senegal	United Rep. of Tanzania		
Bosnia & Herzegovina	Equatorial Guinea	Kuwait	Nauru	Serbia	Uruguay		
Botswana	Eritrea	Kyrgyzstan	Nepal	Sierra Leone	Uzbekistan		
Brazil	Ethiopia	Lao People's Dem. Rep.	Nicaragua	Singapore	Vanuatu		
Brunei Darussalam	Fiji	Latvia	Niger	Solomon Islands	Venezuela		
Bulgaria	French Polynesia	Lesotho	Nigeria	Somalia	Viet Nam		
Burkina Faso	Gabon	Liberia	Niue	South Africa	Yemen		
Burundi	Gambia	Libya	N. Mariana Islands	South Sudan	Zambia		
Cabo Verde	Georgia	Lithuania	Pakistan	Sri Lanka	Zimbabwe		
Cambodia	Ghana	Madagascar	Palau	Sudan			
6. TB SKIN TEST Mantoux skin test only. TB skin tests ARE NOT ACCEPTED from other countries. Date planted: ____/____/____ Date Read: ____/____/____ Result in induration _____ mm If no induration, mark "0"		TB BLOOD TEST (IGRA) <i>Recommended if prior BCG</i> <input type="checkbox"/> Quantiferon <input type="checkbox"/> T-Spot Date: ____/____/____ Result <input type="checkbox"/> NEG <input type="checkbox"/> POS <input type="checkbox"/> INDETERMINATE		CHEST X-RAY: Required within 6 months for past or current positive TB Skin or blood test. X-RAY report must be attached. Chest x-ray date: ____/____/____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		MEDICATION TREATMENT <input type="checkbox"/> Latent (inactive) <input type="checkbox"/> TB Infection <input type="checkbox"/> Active TB Disease Treatment completion date: ____/____/____ List Medication Dose & Frequency	
PART III. REQUEST FOR EXEMPTION							
Religious exemption is allowed if the responsible person objects in good faith, in writing, that immunizations violate his or her religious beliefs. The exemption does not apply to tuberculosis screening. Medical exemption is allowed if a physician or health authority deems an immunization medically inadvisable. Explicit written documentation supporting an exemption request must be submitted. Please go to www.wesleyan.edu/healthservices/pdfdocuments/immunizrequestform.pdf and submit with medical records packet.							

Hold will be placed on your student account until this form is completed.

Wesleyan University Health Services Physical Form

327 High Street, Middletown, CT 06459 Phone: 860-685-2470

Please Fax: (860) 685-2471 or Email forms: healthforms@wesleyan.edu

Last name:	First Name:	MI:	Birthdate:
Email address:	Student Cell Phone:	Gender:	Pronoun:

Allergies and other Adverse Reactions – List all that apply and describe reaction Check here if no allergies

Medication Allergies:	Reaction:	Epi Pen: Y/N
Food Allergies:	Reaction:	Epi Pen: Y/N
Other Allergies: <input type="checkbox"/> Insect/Bees <input type="checkbox"/> IV Contrast <input type="checkbox"/> Latex <input type="checkbox"/> Seasonal/Pollen <input type="checkbox"/> Other		Epi Pen: Y/N

Medications (include prescriptions, birth control, herbal supplements and over-the-counter medications)

Name	Dose	Frequency

Personal Medical History – Student or Provider please circle all that apply Check here if none

ADHD	Diabetes	Musculoskeletal
Alcohol/Drug Abuse/Tobacco	Eating Disorder	Seizures/Convulsions
Anemia	Gastrointestinal Problem	Sickle Cell Anemia
Anxiety/Depression/Mental Illness	Gynecological Disorder	Skin
Asthma	Hepatitis B or C	Tobacco/Vaping/E-cigarettes
Cancer	High Blood Pressure	Thyroid Disease
Cardiac Condition/Heart Murmur	HIV/AIDS	Tuberculosis (latent or active)
Coagulation/bleeding disorder	Meningitis	Urological Disorder
Concussion/Head Injury	Migraines	Other:

Previous hospitalizations or surgeries (include date and year) _____

Please comment on any active/significant medical issues circled above. For concussions, please list dates. For any complex medical or mental health problem that requires ongoing care, **please attach a letter of explanation.**

PHYSICAL EXAM: Normal Abnormal (within the last 2 years)

Height (in): Weight (lb): BP (sitting): Pulse: Temp: BMI: _____
If <18.5 or >30 please comment above

IDENTIFY ABNORMALS:

IMPRESSION (diagnoses, recommendations, restrictions):

PROVIDER SIGNATURE: _____ DATE OF EXAMINATION: _____
PROVIDER NAME: _____ PHONE: _____ FAX: _____

ADDRESS: _____

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 Student Accounts Office *will not* have specific or protected health information included. The Student Accounts Office 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 benefit 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 11/18

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.

COUNSELING AND PSYCHOLOGICAL SERVICES 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 Counseling and Psychological Services (CAPS). This form cannot be released without the student's written consent and the form will NOT affect admission status.

Name: (please print) _____ Date of Birth: ____/____/____ WESID #: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

0 = Not at all	1 = Several days	2 = More than half the days	3 = Nearly every day	
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
10. Feeling nervous, anxious or on edge	0	1	2	3
11. Not being able to stop or control worrying	0	1	2	3
12. Worrying too much about different things	0	1	2	3
13. Trouble relaxing	0	1	2	3
14. Being so restless that it is hard to sit still	0	1	2	3
15. Becoming easily annoyed or irritable	0	1	2	3
16. Feeling afraid as if something awful might happen	0	1	2	3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all Somewhat difficult Very difficult Extremely difficult

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 received counseling or psychotherapy in the past? Yes No
 If yes, date (approx. month(s) and year(s)): _____

C. Are you currently receiving psychiatric services, professional counseling, or psychotherapy? Yes No If yes,
 please provide the mental health provider's name and phone number: _____

D. Are you CURRENTLY taking prescribed psychiatric medication? Yes No
 If yes, please list what medications, dosage, and the prescribing psychiatrist/physician: _____

E. Have you been hospitalized for psychiatric reasons? Yes No
 If yes, please specify reason for past hospitalization: _____

Please specify when and where you were hospitalized: _____

F. Have you purposely injured yourself without suicidal intent? (e.g., cutting, burning, etc.) Yes No If yes,
 please briefly describe: _____

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

H. Do you know of anyone who has died by suicide? Yes No
 If yes, when and how, and your relationship to that person: _____

I. Do you feel you have a problem with any of the following? (Please check as many as apply):
 Alcohol or drug concerns ADHD/learning problems Anger management Eating concerns/body image
 Family problems Identity/sense of self Impulse Control Loss, grief, death Medical/Health concerns
 Panic attacks Relationship concerns Sexuality concerns Trauma (e.g., abuse, assault, etc.)
 Other: _____