Trinity College Health Center with Care Provided by
Hartford HealthCare, Campus Care
300 Summit Street
Hartford, CT 06106-3100
p) 860.297.2018
f) 860.297.2020
e) healthcenter@trincoll.edu

Dear Incoming Student,

Congratulations on your acceptance! We look forward to helping you maintain your health while on campus.

The following is a list of Health Center requirements to obtain housing:

- ☐ **Upload COMPLETED documents to the Student Health Portal:**
  - ☐ **Health care provider completed Health Information, Immunization Documentation & TB Screen**. An up-dated physical is recommended, not required.
  - ☐ **Medical consent** form signed by you and a parent/guardian if you will be under 18 before arriving on campus. We recommend all students submit this consent form prior to arrival, regardless of age.

PLEASE NOTE: The State of Connecticut requires students enrolled at institutions of higher education be vaccinated against **Measles, Mumps, Rubella** (MMR), **Varicella** (chickenpox), and, to live on-campus, **Meningitis**. Appropriately documented medical exemption form must be provided if any required immunizations are medically contraindicated. To request a medical exemption for required vaccination(s), please submit a completed Medical Exemption Form.

If you have questions or concerns regarding the health requirements, please call or email the health center directly.

Staff will review your documents from the portal in the order in which they are received. If there are issues with your requirements, we will contact you.

You also must complete:

- ☐ **Health Insurance:**
  - ☐ ***Refer to the Student Accounts Office for further information on the Health Insurance requirement***.
  - ☐ Action is required if you will be opting out of the Student Health Insurance Plan.
  - ☐ ***AFTER* establishing your insurance coverage with Student Accounts,** upload your insurance card to the **Student Health Portal.**

All students must have active health insurance coverage while they are a student at Trinity College *and are therefore* ***automatically enrolled*** *in the Student Health Insurance Plan (SHIP) and charged the annual premium on their student accounts bill. Students/Families may elect to maintain coverage from home by opting-out of the SHIP by completing an on-line waiver.*
If the SHIP is waived, your home insurance plan dictates benefits and coverage for you while at Trinity College and may not allow access to local Hartford area providers. It is the student's responsibility to know their health insurance policy, utilization and referral guidelines if necessary.
We encourage you to confirm your coverage benefits in our area with a call to your company's Member Services line and inquire about the network available in our zip code, 06106. It may also prove beneficial to inquire if any "away from home" paperwork needs to be completed to ensure continuation of home benefits while on campus.

Sincerely,
The Trinity College Health Center Staff

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CONSENT, completed by student/family

Name:_____
Lived Name: _____

Date of Birth: _____Age: _____
Student Phone: _____Student ID: _____

Emergency Contact: _____Relationship: _____
Emergency Contact Phone: _____

CONSENT FOR CARE AND TREATMENT

I hereby authorize the Trinity College Health Center staff, employed by Hartford HealthCare Medical Group, to provide medical care and treatment to me. For students who are less than 18 years of age, this form must be signed by a parent or legal guardian, thereby permitting the student to obtain health care in the absence of the parent/guardian.

I consent to the use or disclosure of my protected health information by the Health Center to persons or organizations who require such information for the purposes of providing treatment, obtaining payment, or other necessary functions associated with my health care. Protected health information may include evaluation and treatment information related HIV/AIDS, psychiatric and other mental health status, and drug and alcohol treatment. Protected health information will be used or disclosed in accordance with Connecticut and Federal law, which may require you to provide additional, specific written authorization. See the Notice of Privacy Practices on the Health Center's webpage for details regarding how the Health Center will use or disclose my protected health information.

By signing below, I understand and acknowledge the following:

- The Health Center may provide care to me (or my student) on campus while I am at Trinity College.
- I have read the electronic version of the Privacy Practices.
- Information about me (student or parent/guardian), obtained as a result of my signature below, may be shared among employees and agents of the Trinity College Health Center, Dean of Students Office, Counseling Center, and Sports Medicine, on a need-to-know basis.
- Unless revoked by me, this consent will remain in effect during my enrollment as a student at Trinity College, thereafter for a period of seven (7) years, which is the anticipated period that the Health Center will maintain my protected health information.

_____

STUDENT Signature / and Parent/ Guardian (if student is under 18 years of age) **Da**te

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Patient Name: _____ D.O.B. _____ Pronouns: _____

Lived Name: _____ Gender Assigned at Birth: _____ Gender Identity: _____

Student Health Information, Immunization Documentation & TB Screen – *TO BE COMPLETED BY A MEDICAL PROVIDER*

☐ **Please complete the following form.** **Students considering athletics at Trinity require a physical exam sports clearance completed within 6 months of anticipated play. Attach a copy of this student's physical exam/ sports clearance -if applicable.*

Medical / Surgical / Psychiatric History:		
Medications:	Allergies:	Specialists Name & Phone *(if applicable)*:
HT:	WT:	BP:

☐ **Immunization record indicating compliance with CT State law/ Mandatory Vaccines:**

Meningococcal ACYW: One dose within 5 years of residing on campus is required. The Meningitis B vaccine does not fulfuill the requirement.

mm/dd/yyyy ☐☐☐☐☐☐☐☐

MMR: Two doses given at least 28 days apart and after 12 months of age OR postive MMR antibody titer (attach). Doses administered at less than the minimum interval or earlier than the minimum age are not valid and must be repeated.

Dose 1: mm/dd/yyyy ☐☐☐☐☐☐☐☐ Dose 2: mm/dd/yyyy ☐☐☐☐☐☐☐☐ **OR**

Measles
Dose 1: mm/dd/yyyy ☐☐☐☐☐☐☐☐ Dose 2: mm/dd/yyyy ☐☐☐☐☐☐☐☐ **OR** Titer: mm/dd/yyyy ☐☐☐☐☐☐☐☐ Result: _____

Mumps
Dose 1: mm/dd/yyyy ☐☐☐☐☐☐☐☐ Dose 2: mm/dd/yyyy ☐☐☐☐☐☐☐☐ **OR** Titer: mm/dd/yyyy ☐☐☐☐☐☐☐☐ Result: _____

Rubella
Dose 1: mm/dd/yyyy ☐☐☐☐☐☐☐☐ Dose 2: mm/dd/yyyy ☐☐☐☐☐☐☐☐ **OR** Titer: mm/dd/yyyy ☐☐☐☐☐☐☐☐ Result: _____

Varicella: Two doses given at least 28 days apart and after 12 months of age OR postive Varicella antibody titer (attach) OR a history of disease verified by your provider. Doses administered at less than the minimum interval or earlier than the minimum age are not valid and must be repeated.

Dose 1: mm/dd/yyyy ☐☐☐☐☐☐☐☐ Dose 2: mm/dd/yyyy ☐☐☐☐☐☐☐☐ **OR** Titer: mm/dd/yyyy ☐☐☐☐☐☐☐☐ Result: _____ **OR** Disease Date mm/dd/yyyy ☐☐☐☐☐☐☐☐

Please note:

When recording titer results, submit the laboratory testing with this paperwork.

CT State law no longer permits Religious vaccination Exemptions.

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Patient Name: _____ D.O.B. _____

☐ **Tuberculosis (TB) Risk Assessment:**	
1. Have you ever been treated or are you currently being treated for active or latent TB?	☐ Yes ☐ No
2. Have you ever had a positive TB test (skin or blood)?	☐ Yes ☐ No
3. Have you ever received the BCG vaccine?	☐ Yes ☐ No
4. Have you had a persistent cough (> 3 weeks), fever, night sweats, fatigue, loss of appetite or weight?	☐ Yes ☐ No
5. Have you ever lived with or been in close contact with a person with TB?	☐ Yes ☐ No
6. Have you ever lived, worked, or volunteered in any homes shelter, prison/ jail, or health care facility?	☐ Yes ☐ No
7. Have you lived, worked, or travelled to any of the following listed countries for more than or equal to 1 month (cumulative travel). *See list below.*	☐ Yes ☐ No

If answered *no* to all questions:

☐ Low Risk: No TB testing indicated

If answered *yes* to question 1 &/or 2:

☐ Attach test report, if available
☐ Attach Chest X Ray report: x ray report Completed within 3 months of arrival on campus.

Treatment Dates (if indicated): _____

If answered *yes* to any questions 3-7:

TB testing is required <u>within 6 months</u> prior to your arrival on campus.

☐ <u>Attach testing date, type, results</u>

- ***Preferred*** Interferon-Gamma Release Assays (IGRAs) Blood Test (eg: QuantiFERON®-TB Gold In-Tube test (QFT-GIT), T-SPOT®.*TB* test)
- ***Acceptable*** Chest X-ray
- *PPD/ skin test is <u>not</u> acceptable*

ACHA Tuberculosis Screening and Targeted Testing of College & University Students

*If you were born or lived one or more months in any of these countries, **TB testing is required***:

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Burkina Faso
Burundi
Côte d'Ivoire
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
China, Hong Kong SAR
China, Macao SAR
Colombia
Comoros
Congo
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Eswatini
Ethiopia
Fiji
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Malta
Marshall Islands
Mauritania
Mexico
Micronesia (Federated States of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Niue
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Sao Tome and Principe
Senegal
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Tajikistan
Thailand
Timor-Leste
Togo
Tokelau
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

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Patient Name: _____ D.O.B. _____

PROVIDER ATTESTATION STATEMENT

- ☐ I have confirmed this student's vaccinations meet CT State law requirements per guidance provided or have attached the completed Medical Exemption Form.
- ☐ Date of Last Physical Exam: _____.
- ☐ I have completed this student's TB screening per guidance provided.
- ☐ This student may participate fully in club, intramural, and recreational sporting activities.

Signature:_____ MD/NP/PA

Printed Name: _____ Date: _____

Phone: _____

Address or Office Stamp _____