



Hamilton

May 1, 2009

Dear Student and Parents,

On behalf of the staff of the Thomas Brown Rudd Health Center, welcome to Hamilton College. We are pleased you have selected Hamilton and look forward to working with you over the next four years. The health center staff is dedicated to encouraging and maintaining the health of all students. Medical and nursing services at the Student Health Center are available to all students without additional cost, although charges may be incurred for tests, medications, outside consultations and hospitalizations.

Enclosed in this packet you will find a health form that requires a physical exam done within one year (from start of classes), immunization records, and a TB Mantoux test. I encourage you to schedule your appointment with your healthcare provider as soon as you receive this packet. Please be sure to let us know about any special health problems or considerations. The health form packet needs to be completed and returned to our office by August 7, 2009, for students entering in fall 2009 or spring 2010 semesters.

On July 22, 2003, Governor Pataki signed New York State Public Health Law (NYS PHL) §2167 requiring institutions, including colleges and universities, to distribute information about meningococcal disease and vaccination to all students meeting enrollment criteria, whether they live on or off campus. This law became effective on August 15, 2003. Please check with your primary healthcare provider or local health department for availability and cost for this vaccine. If you decide not to receive the meningococcal meningitis immunization, the declination on the immunization record form under letter "J" must be signed by the student.

Hamilton College requires that all enrolled students carry some form of valid health insurance coverage. All students who are U.S. citizens or permanent residents are automatically enrolled in the Hamilton College Student Health Insurance Plan. If you have sufficient existing health insurance coverage and DO NOT wish to purchase the Hamilton College coverage, you must submit an on-line waiver and present evidence of your own annual health insurance coverage. The waiver form is available at www.ajfusa.com or as a link from www.hamilton.edu/college/health_center. Please be aware that coverage cannot be waived after September 10, 2009 (annual Coverage) or January 10, 2010 (spring 2010 coverage). Please see the page that follows for additional information about this coverage and the waiver process.

You will need your Hamilton College Student identification number to complete the online waiver. To obtain your student identification number, login to <https://my.hamilton.edu> with your user name and password and under Other Useful Resources, click on the link for Health Insurance Waiver and your student identification number will be posted.

Students who are not U.S. citizens are eligible for health insurance coverage offered through the Dean of Students Office. Information about this policy is available at www.hamilton.edu/college/dean_of_students.

Please be sure to notify the health center of any changes in your coverage. Also, be sure to carry a copy of your insurance card with you while you are a student at Hamilton.

We look forward to working with you and hope your stay at Hamilton will be healthy and happy.

Sincerely,

Christine C. Merritt, NP/RPA-C
Director, Student Health Services

Meningococcal Disease

What is meningococcal disease?

Meningococcal disease is a severe bacterial infection of the bloodstream or meninges (a thin lining covering the brain and spinal cord) caused by the meningococcus germ.

Who gets meningococcal disease?

Anyone can get meningococcal disease, but it is more common in infants and children. For some adolescents, such as first year college students living in dormitories, there is an increased risk of meningococcal disease. Every year in the United States approximately 2,500 people are infected and 300 die from the disease.

How is the meningococcus germ spread?

The meningococcus germ is spread by direct close contact with nose or throat discharges of an infected person.

What are the symptoms?

High fever, headache, vomiting, stiff neck and a rash are symptoms of meningococcal disease. The symptoms may appear 2 to 10 days after exposure, but usually within 5 days. Among people who develop meningococcal disease, 10-15% die, in spite of treatment with antibiotics. Of those who live, permanent brain damage, hearing loss, kidney failure, loss of arms or legs, or chronic nervous system problems can occur.

What is the treatment for meningococcal disease?

Antibiotics, such as penicillin G or ceftriaxone, can be used to treat people with meningococcal disease.

Should people who have been in contact with a diagnosed case of meningococcal meningitis be treated?

Only people who have been in close contact (household members, intimate contacts, health care personnel performing mouth-to-mouth resuscitation, day care center playmates, etc.) need to be considered for preventive treatment. Such people are usually advised to obtain a prescription for a special antibiotic (rifampin, ciprofloxacin or ceftriaxone) from their physician. Casual contact, as might occur in a regular classroom, office or factory setting, is not usually significant enough to cause concern.

Is there a vaccine to prevent meningococcal meningitis?

In February 2005, the CDC recommended a new vaccine, known as Menactra™, for use to prevent meningococcal disease in people 11-55 years of age. The previously licensed version of this vaccine, Menomune™, is available for children 2-10 years old and adults older than 55 years. Both vaccines are 85% to 100% effective in preventing the 4 kinds of the meningococcus germ (types A, C, Y, W-135). These 4 types cause about 70% of the disease in the United States. Because the vaccines do not include type B, which accounts for about one-third of cases in adolescents, they do not prevent all cases of meningococcal disease.

Are the vaccines safe? Are there adverse side effects to the vaccine?

Both vaccines are currently available and both are safe and effective vaccines. However, both vaccines may cause mild and infrequent side effects, such as redness and pain at the injection site lasting up to two days.

Who should get the meningococcal vaccine?

The vaccine is recommended for all adolescents entering middle school (11-12 years old) and high school (15 years old), and all first year college students living in dormitories. However, the vaccine will benefit all teenagers and young adults in the United States. Also at increased risk are people with terminal complement deficiencies or asplenia, some laboratory workers, and travelers to endemic areas of the world.

What is the duration of protection from the vaccine?

Menomune™, the older vaccine, requires booster doses every 3 to 5 years. Although research is still pending, the new vaccine, Menactra™, will probably not require booster doses.

How do I get more information about meningococcal disease and vaccination?

Contact your family physician or your student health service. Additional information is also available on the websites of the New York State Department of Health, www.health.state.ny.us; the Centers for Disease Control and Prevention www.cdc.gov/ncid/dbmd/diseaseinfo; and the American College Health Association, www.acha.org.

PLEASE RETURN BY AUGUST 7th

Thomas B. Rudd Health Center, Hamilton College, 198 College Hill Road, Clinton, NY 13323

Telephone 315-859-4111; Fax 315-859-4963 • Website: http://www.hamilton.edu/college/health_center

Last Name		First Name		Middle Name		
Address		City		State	Country (If not U.S.A.)	Zip + 4
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth (Month/Day/Year) ___/___/___		Social Security # ___ ___ ___/___ ___/___ ___		
E-Mail Address			Student Cell Phone #			
Parents/Guardian		Relationship		Daytime Phone <input type="checkbox"/> Work or <input type="checkbox"/> Home		
Home Address				Evening Phone <input type="checkbox"/> Work or <input type="checkbox"/> Home		
Emergency Contact Name		Home Address		Daytime Phone		
E-Mail Address		Relationship		Evening Phone		

SPECIAL NEEDS

Do you believe that you have any special needs that the College should consider in order to provide assistance with living and learning conditions?

- | | |
|---|--|
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Motor Deficits | <input type="checkbox"/> Dietary |
| <input type="checkbox"/> Vision | <input type="checkbox"/> Learning |
| <input type="checkbox"/> Speech | <input type="checkbox"/> Psychological |
| <input type="checkbox"/> Other | |

Describe: _____

The Associate Dean of Students for Diversity and Accessibility is available to discuss your concerns. Phone 315-859-4021.

Please Attach
Recent Photograph

I consent to the medical treatment by the staff of the Hamilton College Health Center, emergency medical technicians, covering physicians at local urgent care facilities and local hospitals. I understand I may incur charges for services provided to me by these facilities. I have read and understand my patient's rights and responsibilities as described within.

Student Signature

Date of Signatures

Parent Signature

Please complete this form before going to your health care provider for an examination (please print).

Family Medical History

Adopted _____ Yes _____ No

	Age	State of Health	Occupation	Age at Death	Cause of Death
Father					
Mother					
Brothers					
Sisters					

Immediate Family Only

	Yes	Relationship
Diabetes		
Kidney Disease		
Heart Disease		
High Blood Pressure		
Arthritis		
Cancer		
Epilepsy/Convulsions		

PERSONAL HISTORY: PLEASE ANSWER ALL QUESTIONS. *Comment on all positive answers in space below.*

HAVE YOU HAD?	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Acne (on medication)			Fainting Spells			Mononucleosis			ALLERGY TO: Medications: If yes, please specify below			SURGERY: Appendectomy Tonsillectomy Hernia Repair Other (describe)		
ADD/ADHD			Frequent Anxiety			Palpitations (Heart)								
Anemia			Frequent Depression			Seizures								
Asthma			Gallbladder Trouble			Sexual Transmitted Diseases								
Back Problems			Head Injury			Sinusitis			Insect Bites			FEMALES ONLY: Irregular Periods Severe Cramps Pap within 1 year <i>Please enclose copy.</i>		
Chicken Pox			w/Unconsciousness			Stomach or Intestinal Trouble			Foods (which)					
Concussion			Heart Murmur			Throat Infections			Other (explain)					
Disease/Injury of Joints			High Blood Pressure			Thyroid Problems			Do you currently get allergy shots? <i>Please see website for instructions.</i>					
Diabetes			Insomnia			Tuberculosis								
Ear Infections			Lyme Disease			Tumor/Cancer (explain)								
Eating Disorder			Malaria			Urine Infection								
Eye Trouble			Migraines											

Explain any yes answers from above: _____

Have you received counseling or been hospitalized for mental health or psychiatric care? ___ Yes ___ No
If yes, please explain: _____

Please list any current medications: prescription, over the counter, and herbal medications, including birth control pills: _____

Any additional pertinent information: _____

REPORT OF HEALTH EVALUATION

TO THE EXAMINING HEALTH CARE PROVIDER: Please review the student's history and complete the physical form. Please comment on all positive answers.

THIS STUDENT HAS BEEN ACCEPTED. The information supplied will not affect the student's status: it will be used only as a background for providing health care, if this is necessary. This information is strictly for the use of the Health Services and will not be released without student consent.

_____ SEX: ___ M ___ F
Last Name First Name Middle Name

Date of Physical Exam: _____ **Required within one year prior to start of classes.**
Month/Day/Year

STUDENTS TAKING MEDICATION FOR ADD/ADHD WILL NOT BE ABLE TO OBTAIN PRESCRIPTIONS FOR REFILLS FROM THE THOMAS BROWN RUDD HEALTH CENTER. PLEASE MAKE ARRANGEMENTS FOR REFILL PRESCRIPTIONS WITH YOUR PATIENT.

Height (Inches) _____ Weight (Pounds) _____ BP _____/_____ Pulse _____

Any allergies to medication(s)/food(s)? ___ No ___ Yes/Explain: _____

Are there abnormalities of the following systems? If yes, describe in full. Use an additional sheet of paper if necessary.

- ___ No ___ Yes 1.) Head, Ears, Nose or Throat: _____
- ___ No ___ Yes 2.) Eyes: _____
- ___ No ___ Yes 3.) Respiratory: _____
- ___ No ___ Yes 4.) Cardiovascular: _____
- ___ No ___ Yes 5.) Gastrointestinal: _____
- ___ No ___ Yes 6.) Hernia: _____
- ___ No ___ Yes 7.) Genitourinary: _____
- ___ No ___ Yes 8.) Musculoskeletal: _____
- ___ No ___ Yes 9.) Metabolic/Endocrine: _____
- ___ No ___ Yes 10.) Neuropsychiatric: _____
- ___ No ___ Yes 11.) Skin: _____

Have you any general comments: _____

If you answer yes to any of the following questions, please give further details.

Is there loss or seriously impaired function of any paired organ? ___ No ___ Yes _____

Recommendations for physical activity (PE, Intramurals, Collegiate): ___ Unlimited ___ Limited, Explain: _____

Currently on any long term medications? ___ No ___ Yes/What?: _____

Has physical activity been restricted in the past 2 years? ___ No ___ Yes/Explain: _____

Do you have any recommendation regarding the care of this student: ___ No ___ Yes/Explain: _____

Health Care Provider (Please Print) _____ Phone: _____

Address: _____

Health Care Provider's Signature: _____ Fax: _____

HAMILTON COLLEGE IMMUNIZATION RECORD FORM
Immunity is required prior to registration. Please complete and return this form.

Name: _____ Date of Birth: ____/____/____
Last Name First Name MI

TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER. All information must be in English and listed by Month, Day and Year.

New York State Public Health Law requires that all students born after December 31, 1956 be adequately immunized against Measles, Mumps and Rubella. **You are legally required to provide this information and to get the necessary immunizations, or you will be DENIED enrollment.** If you qualify for a medical or religious exemption, please provide written documentation.

Required by New York State Law:

A. M.M.R. (Measles, Mumps, Rubella) (two doses required or individual vaccine as noted below)

- 1. Dose 1 given at 12 months after birth or later1. ____/____/____
- 2. Dose 2 given no sooner than 30 days after Dose 1.....2. ____/____/____

B. Measles (Rubeola) (check all that apply)

- 1. Immunized with live vaccine at 12 months after birth or later 1. ____/____/____ 2. ____/____/____
- 2. Has report of positive immune titer. Specify date..... ____/____/____
- 3. Had disease confirmed by doctor's records..... ____/____/____

C. RUBELLA (German Measles) (clinical history is not acceptable) (check all that apply)

- 1. Immunized with live measles vaccine at 12 months after birth or later 1. ____/____/____
- 2. Has report of positive immune titer. Specify date..... ____/____/____

D. MUMPS (check all that apply)

- 1. Immunized with live vaccine at 12 months after birth or later 1. ____/____/____
- 2. Has report of positive immune titer. Specify date..... ____/____/____
- 3. Had disease confirmed by doctor's records..... ____/____/____

E. TETANUS-DIPHTHERIA (Primary series with DtaP or DTP and booster with Td in the last ten years meets requirement.)

- 1. Primary series of four doses with DtaP or DTP1. ____/____/____ 2. ____/____/____ 3. ____/____/____ 4. ____/____/____ 5. ____/____/____
- 2. Tetanus-Diphtheria (Td) booster within the last ten years Received Td ____ or Tdap ____ ____/____/____

F. TUBERCULOSIS (*PPD required within the past 12 months regardless of prior BCG inoculation and risk assessment.*)

- 1. PPD (Mantoux) within the past 12 months (tine or momovac not acceptable)
Date Placed: ____/____/____ Date Read: ____/____/____ Result: ____ mm induration (NO SELF READS)
- 2. If greater than 10 mm induration, chest x-ray required.X-ray Result: Date: ____/____/____ Normal ____ Abnormal ____
- 3. Treated with INH Yes ____ No ____ Duration _____ Months. Was treatment completed? _____
- 4. Received BCG: Yes ____ No ____ If yes: when?: ____/____/____

G. POLIO

- 1. Type of vaccine: Live (OPV)____ Inactivated (IPV)____ Enhanced Potency (EP-IPV)____
Primary Series: 1. ____/____/____ 2. ____/____/____ 3. ____/____/____ 4. ____/____/____ Date of Booster: ____/____/____

The following, H-L are only recommended:

H. HEPATITIS B (recommended) 1. ____/____/____ 2. ____/____/____ 3. ____/____/____
Hepatitis B surface antigen antibody ____/____/____ Reactive ____ Non-reactive ____

I. VARICELLA Hx of Disease Date ____/____/____ Vaccinated 1. ____/____/____ 2. ____/____/____

J. MENINGITIS Received ____/____/____ Menomune ____ or Menactra ____
I have been informed regarding the risks of Meningitis and **decline** the immunization.

Student Signature *Date*

K. HEPATITIS A 1. ____/____/____ 2. ____/____/____

L. HPV Vaccine 1. ____/____/____ 2. ____/____/____ 3. ____/____/____

HEALTH CARE PROVIDER (please print)

Name _____ Address _____
Signature _____ Phone (____) _____
Fax (____) _____

Patient's Rights and Responsibilities

The patient has a right

- to be treated with respect and dignity and to be provided with courteous, considerate care;
- to be informed about the diagnosis, treatment and prognosis of the health problem in terms that can be understood;
- to know the chances that treatment will be effective and to know the possible risks, side effects and alternative methods of treatment;
- to receive confidential treatment of their disclosures and medical records and, except when required by law, afforded the opportunity to approve or refuse their release;
- to know the name and professional status of those treating you;
- to have access to a second medical opinion before making any decision. The patient can decide not to be treated, but must be informed of the medical consequences of refusal;
- to participate in decisions involving the health problem;
- to be informed of the personal responsibilities involved in seeking medical treatment and maintaining health and well-being thereafter;
- to privacy;
- to have access to resource persons and information concerning health education, self-care and prevention of illness;
- to be given appropriate and professional quality health care without discrimination against their race, creed, color, religion, sex, national origin, sexual preference, handicap or age;
- to voice grievance with health care services and/or staff without being threatened, restrained and discriminated against.

The patient has a responsibility

- to inform clinician of any changes in his/her health status that could affect treatment;
- to adhere to a prescribed treatment plan and to discuss any desired change;
- to act in a considerate and cooperative manner with the Student Health Service staff;
- to ask questions and seek clarification regarding areas of concern;
- to weigh the consequences of refusing to comply with instructions and recommendations;
- to assist the clinicians in compiling a complete record by authorizing the Student Health Service to obtain necessary medical information from appropriate sources;
- to inform staff if he/she has a prescription card at the time of appointment;
- to keep appointments on time; or cancel appointment in a timely manner.
- to respect the Health Center policies.