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 Health Center, located in Trinity Hall, provides health care to all graduate students enrolled in at least two classes. We can also facilitate referrals to local specialists as needed. While the Health Center is owned by Trinity College, the staff are contracted employees through a partnership with Hartford HealthCare Medical Group.

The following is a list of requirements in order for students to obtain housing:

- ☐ **Consent and Health & Immunizations Form**:
  - ☐ Print and complete the top section of the Consent and Immunizations Form (see below).
  - ☐ Have your health care provider complete the bottom.
  - ☐ **Upload the completed form to the Student Health Portal**.

The State of Connecticut requires students enrolled at institutions of higher education to be vaccinated against **Measles, Mumps, Rubella** (MMR), **Varicella** (chickenpox) and **Meningitis**. Appropriately documented medical exemption must be on file in the event that any required immunizations are contraindicated. Public Act 21-6 states that only medical exemptions are permissible. To request a medical exemption for required vaccination(s), please submit a completed Medical Exemption Form.
If you cannot get any of the above requirements in your home country, please email healthcenter@trincoll.edu and schedule an appointment to complete these requirements once you arrive.

- ☐ **Physical examination:** Required.

- ☐ **Tuberculosis (TB) Testing:** If your country of citizenship/home country is considered by the World Health Organization to have a "high incidence" of TB, you must be screened within 3 months of coming to campus. To check the list of "high incidence" countries please check here.
  - Interferon-Gamma Release Assays (IGRAs) Blood Test, *preferred*
    (eg: QuantiFERON®-TB Gold In-Tube test (QFT-GIT), T-SPOT®.*TB* test)
  - **Chest X-ray, *acceptable***
    You will need an appointment at the Health Center for further evaluation upon arrival.
  - **If you are unable to complete this screening, schedule at the Health Center on arrival.**

Once you have uploaded all of the required forms into your first year portal, the Health Center will review the information and determine if it is acceptable. If all requirements are met, the task will be changed to "COMPLETE". If there are items still missing, you will be contacted and informed of what is still needed.

You must also compete the following:

- ☐ **Health Insurance:**
  - ☐ **Refer to the Student Accounts Office for further information on the Health Insurance requirement.**

All students must have active health insurance coverage while they are a student at Trinity. As an international student you are automatically enrolled in International Student Health Insurance coverage [I-SHIP] and billed the premium on your student account.

Sincerely,
The Trinity College Health Center Staff

Partnered with Hartford HealthCare

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CONSENT, completed by student/family

Name:_____Date of Birth:_____Age:_____

Student Phone: _____Student ID: _____

Emergency Contact: _____Relationship:_____

Emergency Contact Phone: _____

CONSENT FOR CARE AND TREATMENT

I hereby authorize the Health Center staff employed by Hartford HealthCare Medical Group to provide medical care and treatment to me. This authorization will remain in effect as long as I am a student at Trinity College. In the case of a minor (under 18) a parent or legal guardian's signature below permits the student to obtain health care in the absence of the guardian. Information obtained from care provided or from these forms may be shared among Health Center staff, Dean of Students, Counseling Center staff and Sports Medicine Staff.

I consent to the use or disclosure of my protected health information by the Health Center to any person or organization for the purposes of carrying out treatment, obtaining payment or conducting certain healthcare operations. Protected health information used or disclosed may include HIV/AIDS related information, psychiatric and other mental health information, and drug and alcohol treatment information, as long as such information is used or disclosed in accordance with Connecticut and Federal law, which may require you to provide specific written authorization. I understand that information regarding how the Health Center will use and disclose my information can be found in the Notice of Privacy Practices on the Health Center's webpage. I understand that this consent is effective for as long as the Health Center maintains my protected health information, which is 7 years after my graduation date.

By signing below, I understand and acknowledge the following:

- The Health Center may provide care to me on campus while I am at Trinity College.
- I have read the electronic version of the Privacy Practices.

Signature of Student / and Parent/ Guardian (if student is under 18 years of age) Date

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Completed by health provider - Health Information and Immunization Documentation

Patient Name:_____D.O.B. _____Date:_____

Date of Exam:_____

Current medications and dosage:	
Allergies:	
Chronic Medical/Mental Health conditions:	
Specialist Name and phone (if applicable):	
Pertinent Family/Social/Surgical history:	
Tuberculosis Risk Assessment: ❖ TB Testing Options: ❖ Interferon-Gamma Release Assays (IGRAs) Blood Test, *preferred* (eg: QuantiFERON®-TB Gold In-Tube test (QFT-GIT), T-SPOT®.*TB* test) ❖ **Chest X-ray, *acceptable***	□ Low Risk: No TB testing is indicated □ High Risk: If student's country of origin is a "high incidence" country, TB testing is required □ Test Type:_____ Result:_____ Date: _____ Treatment *(if indicated)*:

HT:	**WT:**	**BMI:**	**BP:**	**HR:**	**RR:**

General:	
Skin:	
HEENT:	
Heart:	
Lungs:	
Abdomen:	
Musculoskeletal:	
Neuro:	

□ **This patient may participate fully in club, intramural, and recreational sporting activities.**

Signature:_____MD/NP/PA Date:_____

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Patient Name:_____D.O.B. _____Date:_____

STATE LAW/MANDATORY VACCINES: INCLUDE COPY OF CHILDHOOD IMMUNIZATION RECORD

1. Meningococcal A, C, Y, and W-135: one dose AFTER age 16 and WITHIN 5 years of enrollment
2. Two doses of Measles, Mumps, Rubella: first dose after 12 months of age, second at least 30 days after first
3. Two doses of Varicella: first dose after 12 months of age, second at least 30 days after first
4. Trinity College highly recommends remaining up-to-date with your COVID vaccinations and receiving your Meningitis B and Tetanus vaccinations.

Date Format - MM/DD/YYYY

REQUIRED			
Meningococcal ACWY		Age _____	
MMR			OR: obtain serology and attach
Varicella			OR: obtain serology and attach
	Or date of varicella illness:		
RECOMMENDED			
SARS COVID-19	Manufacturer:	Manufacturer:	Manufacturer:
Meningococcal B			
Tetanus			

If there is a medical reason why any of the required vaccinations have not been administered, please complete the Medical Exemption Form.

Signature:_____MD/NP/PA Date:_____

Phone:_____

Address or Office Stamp: _____

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