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
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:**
  - ☐ **Consent for Care and Treatment** form signed by you and a parent/guardian if you are under 18.
  - ☐ **Health care provider completed Health Information, Immunization Documentation & TB Screen**. An up-dated physical is recommended, not required.

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-ACWY**. An 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 via Secure Message through the Student Health Portal.

You also must complete:

- ☐ **Health Insurance:**
  - ☐ ***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 charge 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 by calling 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 for Care and Treatment – ***TO BE COMPLETED BY THE STUDENT / FAMILY***

Given 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) Date

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

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

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

Please complete the following form. **Students considering athletics at Trinity require 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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Student Health Information, Immunization, Documentation & TB Screen – *TO BE COMPLETED BY A MEDICAL PROVIDER*

Given Name: _____ Lived Name: _____D.O.B. _____

Asymptomatic, Tuberculosis (TB) Risk Assessment*:	
1. Has this student ever had a positive TB test of any kind?	□ Yes □ No
2. Has this student ever lived with or been in close contact with a person with TB?	□ Yes □ No
3. Has this student ever worked or volunteered in a homeless shelter, prison/ jail, or health care facility?	□ Yes □ No
4. Was this student born in, ever lived in &/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 NO to <u>all</u> questions:
- □ Low Risk, no TB testing indicated

If YES to question 1, please:
- □ Attach test report/ result, if available
- □ If treated for active or latent TB, attach documentation of completed treatment regimen
- □ Attach Chest X Ray report (*x ray report must be completed **within 3 months** of arrival on campus*)

If YES to questions 2, 3 or 4: <u>TB testing is REQUIRED</u>
- □ The test date must be **within 6 months*** of the student's arrival on campus
- □ Attach testing date, test type & results

❖ *Requested Testing Options:* Interferon-Gamma Release Assay (IGRA) Blood Test <u>or</u> Chest X-ray report *with interpretation.*

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
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
China, Hong Kong SAR
China, Macao SAR
Colombia
Comoros
Congo (Democratic Republic of)
Cote d'Ivoire
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
Korea (Democratic People's Republic of)
Korea (Republic of)
Kyrgyzstan
Lao People's Democratic Republic
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mexico
Micronesia (Federated States of)
Moldova (Republic 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
Romania
Russian Federation
Rwanda
Sao Tome and Principe
Senegal
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Tajikistan
Tanzania (United Republic of)
Thailand
Timor-Leste
Togo
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

**American College Health Association, Tuberculosis Screening and Targeted Testing of College and University Students, 2024*
***Source: World Health Organization Global Health Observatory, Tuberculosis Incidence. Countries with average incidence rates of ≥ 20 cases per 100,000 population.*

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PROVIDER ATTESTATION STATEMENT

Given Name: _____ Lived Name: _____ D.O.B. _____

- ☐ I have confirmed this student's vaccinations meet CT State law requirements per guidance provided or have attached the completed Medical Exemption Form.
- ☐ I have completed this student's TB screening by guidance provided.
- ☐ Date of Last Physical Exam: _____.
- ☐ This student may participate fully in club, intramural, and recreational sporting activities.
- ☐ This student may participate in club, intramural, and recreational sporting activities with the following restrictions/ adaptations: _____.
- ☐ This is the student's medical home (if applicable).

Signature:_____ MD/NP/PA

Printed Name: _____ Date: _____

Phone: _____

Address or Office Stamp: _____