Trinity College | Hartford HealthCare

Dear Incoming Student,

Welcome to Trinity College! 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 the following COMPLETED NEW STUDENT FORMS 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, and required for sports participation.

PLEASE NOTE: The State of Connecticut requires students enrolled at institutions of higher education be vaccinated against **Measles, Mumps, Rubella** (MMR), **Varicella** (chickenpox), and **Meningitis-ACWY** (which is required for students residing on-campus). 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.** If you have insurance related questions, please contact Student Accounts.

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 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
Trinity College Health Center
300 Summit Street
Hartford, CT 06106
p) 860-297-2018
f) 860-297-2020
e) healthcenter@trincoll.edu

Trinity College | Hartford HealthCare

Given Name: _____
Lived Name (if differs): _____
D.O.B. _____

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 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 to 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 child or ward) on campus 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.
- The cost of health center office visits and associated in-office charges will post to my student account and I agree to pay Trinity College for services rendered. Any off-site care, such as specialist referrals or laboratory samples to Quest Diagnostics, will use my insurance for payment and this office will provide my insurance information that I have submitted as a courtesy to the off-site care provider; this action does not guarantee coverage, and I accept responsibility for fees rendered.

_____

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

Trinity College | Hartford HealthCare

Given Name: _____
Lived Name (if differs): _____
D.O.B. _____

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 physical exam sports clearance and sickle cell screening. Attach a copy of this student's physical exam/ sports clearance and sickle cell screening results, if applicable.*

Medical / Surgical / Psychiatric History:			
Medications:	Allergies:	Specialists Name & Phone *(if applicable)*:	
HT:	WT:	BP:	Date of Last Exam:
Gender Assigned at Birth:	Gender Identity:	Pronouns:	

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.

Religious exemptions are not accepted in accordance with CT Public Act No. 21-6.

Select all that apply:

- ☐ I have confirmed this student's vaccinations meet CT State law requirements per guidance provided or have attached the completed Medical Exemption Request Form (*required*).
- ☐ I have completed and attached this student's sports pre-participation form and sickle cell screening results (*recommended, not required*).
- ☐ This is the student's medical home (*recommended, not required*).

Signature: _____ MD/DO/NP/PA Date: _____

Printed Name: _____ Phone Number: _____

Address or Office Stamp: _____

Trinity College | Hartford HealthCare

Given Name: _____
Lived Name (if differs):_____
D.O.B. _____

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

Asymptomatic, Tuberculosis (TB) Risk Assessment*:	
Have you ever had close contact with persons known or suspected to have active TB disease?	□ Yes □ No
Were you born in one of the countries or territories listed below (Appendix 2) that have a high incidence of active TB disease? (If yes, please CIRCLE the country, below.)	□ Yes □ No
Have you resided in or traveled to one or more of the countries or territories listed above for a cumulative period of one to three months or more? (If yes, CHECK the countries or territories, above)	□ Yes □ No
Have you been a resident, volunteer, and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? See list below**	□ Yes □ No
Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease?	□ Yes □ No
Have you ever been a member of any of the following groups that may have an increased incidence of inactive TB infection or active TB disease: medically underserved, low-income, or using drugs or alcohol	□ Yes □ No

If NO to all questions:

□ Low Risk, no TB testing indicated

If YES to any question, TB testing is REQUIRED:

□ Attach test report with name, date, result
The test date must be **within 6 months*** of the student's arrival on campus

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

□ **If treated for active or latent TB**, attach documentation of completed treatment regimen and attach Chest X Ray report with interpretation (*x ray report must be completed **within 3 months** of arrival on campus*)

□ I have completed this student's TB screening by guidance provided.

Signature:_____ MD/DO/NP/PA Date: _____

Printed Name: _____ Phone Number: _____

Address or Office Stamp: _____

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
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 Risk Assessment and Management, April 2025.*

This form should be placed into the athlete's medical file and should *not* be shared with schools or sports organizations. The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.

Disclaimer: Athletes who have a current Preparticipation Physical Evaluation (per state and local guidance) on file should not need to complete another History Form.

PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, non-binary, or another gender): _____

Have you had COVID-19? (check one): ☐ Y ☐ N

Have you been immunized for COVID-19? (check one): ☐ Y ☐ N If yes, have you had: ☐ One shot ☐ Two shots ☐ Three shots ☐ Booster date(s) _____

List past and current medical conditions. _____

Have you ever had surgery? If yes, list all past surgical procedures. _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Unsure**	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?			
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?			
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?			

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		

MEDICAL QUESTIONS	Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease? **Unsure**		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		

MENSTRUAL QUESTIONS	N/A	Yes	No
29. Have you ever had a menstrual period?			
30. How old were you when you had your first menstrual period?			
31. When was your most recent menstrual period?			
32. How many periods have you had in the past 12 months?			

Explain "Yes" answers here.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

This form should be placed into the athlete's medical file and should *not* be shared with schools or sports organizations. The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.

Disclaimer: Athletes who have a current Preparticipation Physical Evaluation (per state and local guidance) on file should not need to complete another examination.

PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

1. Consider additional questions on more-sensitive issues.
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N		
COVID-19 VACCINE		
Previously received COVID-19 vaccine: ☐ Y ☐ N		
Administered COVID-19 vaccine at this visit: ☐ Y ☐ N If yes: ☐ First dose ☐ Second dose ☐ Third dose ☐ Booster date(s) _____		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.

■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

□ Medically eligible for all sports without restriction

□ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

_____

_____

□ Medically eligible for certain sports

_____

_____

□ Not medically eligible pending further evaluation

□ Not medically eligible for any sports

Recommendations: _____

_____

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

_____

_____

Medications: _____

_____

_____

Other information: _____

_____

_____

Emergency contacts: _____

_____

_____