



Thomas Brown Rudd Health Center

# Hamilton

May 1, 2012

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. For more information about services offered at the health center, please visit our website at [www.hamilton.edu/collegehealth\\_center](http://www.hamilton.edu/collegehealth_center).

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 risk assessment form. 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, 2012**, for students entering in fall 2012 or spring 2013 semesters.

New York State Law requires us to distribute information about meningococcal disease and vaccination to all students. Please talk with your health care provider about this vaccine. **If you decide not to receive the meningococcal meningitis vaccine, you must sign the declination on the immunization record page of the health form packet.**

**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 of the U.S. and do not complete the online waiver are automatically enrolled in the Hamilton College Student Health Insurance Plan.** If you have comparable 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 health insurance coverage. It is advised that you contact your health insurance carrier regarding your health insurance coverage while in college. The waiver form is available at [www.GallagherKoster.com/Hamilton](http://www.GallagherKoster.com/Hamilton) or as a link from [www.hamilton.edu/healthcenter](http://www.hamilton.edu/healthcenter). Please be aware that coverage cannot be waived after August 7, 2012 (annual coverage from 8/13/12-8/12/13, premium cost \$660) or January 10, 2013 (spring coverage only from 1/1/13-8/12/13, premium cost \$400). Students entering for the spring 2013 semester are eligible for the 2013 spring term coverage only, not for the 2012-2013 annual coverage. **Please see the enclosed insert for instructions on the waiver process.** For questions or a policy brochure, contact Gallagher Koster at [www.GallagherKoster.com/Hamilton](http://www.GallagherKoster.com/Hamilton) or 1-877-308-0473 or 1-617-769-6091.

You will need your Hamilton College e-mail address and student identification number to complete the online waiver. For more information and to obtain your e-mail address and student identification number, please go to <https://my.hamilton.edu/healthcenter/waiver-instructions>.

Students who are not U.S. citizens or permanent residents are eligible for health insurance coverage offered through the Dean of Students Office. Information about this policy is available at <http://my.hamilton.edu/dos/international-student-services/international-medical-insurance>

Please notify the health center of any changes in your health insurance 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,

Barbara Fluty, RPA-C  
Interim 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](http://www.health.state.ny.us); the Centers for Disease Control and Prevention [www.cdc.gov/ncid/dbmd/diseaseinfo](http://www.cdc.gov/ncid/dbmd/diseaseinfo); and the American College Health Association, [www.acha.org](http://www.acha.org).

**REQUIRED BY AUGUST 7th**

*Failure to return required health form will result in a hold for class registration,  
as well as participation in the Adirondack Adventure program.*

**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](http://www.hamilton.edu/college/health_center)

Last Name		First Name		Middle Name		
Address		City	State	Country (If not U.S.A.)	Zip + 4	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth (Month/Day/Year) ___/___/___				
E-Mail Address			Student Cell Phone #			
Parents/Guardian		Relationship	Daytime Phone	<input type="checkbox"/> Work	<input type="checkbox"/> Home	<input type="checkbox"/> Cell
Home Address		Evening Phone		<input type="checkbox"/> Work	<input type="checkbox"/> Home	<input type="checkbox"/> Cell
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 hereby grant permission to the authorized representatives of Hamilton College Student Health Center and Emergency Medical Technicians to provide medical care while I am a student of Hamilton College. This also includes referrals to outside providers, local hospitals and urgent care facilities. I understand I may incur charges for services provided to me and it is my responsibility to provide valid health insurance information upon request. 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

**Immediate Family Only**

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

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

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

HAVE YOU HAD?	Yes	No		Yes	No		Yes	No	ALLERGY TO:	Yes	No	SURGERY:	Yes	No
Acne (on medication)			Head Injury			Pneumothorax			Medications:			Appendectomy		
ADD/ADHD			w/Unconsciousness			Seizures			If yes, please specify below			Tonsillectomy		
Anemia			Heart: Palpitations/			Sexual				Hernia Repair			Other (describe)	
Anxiety/Depression			Long QT Syndrome			Transmitted Infections			Insect Bites					
Asthma			High Blood Pressure			Sickle Cell Dis./Trait.			Foods (which)					
Blood/Clotting Disorder			Kidney Disease			Sinusitis			Other (explain)					
Cancer/Tumor			Lyme Disease			Sleep Disorders			Do you currently get allergy shots?*					
Concussion			Malaria			Stomach or								
Diabetes			Marfans Syndrome			Intestinal Trouble								
Disease/Injury of Joints			Migraines			Suicide Attempts								
Eating Disorder			Mononucleosis			Thyroid Disease								
Eye Trouble			Obsessive Compulsive Disorder			Tuberculosis								
						Vision/Hearing Impair.								

*\*For allergy shot information please see website: [www.hamilton.edu/healthcenter/care](http://www.hamilton.edu/healthcenter/care) for instructions.*

**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:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Physical examination is to be completed by your Health care Provider and is required one year prior to arrival at Hamilton College.**

	<input type="checkbox"/> M <input type="checkbox"/> F			
Last Name	First name	Gender	DOB MM DD YYYY	Date of Exam MM DD YYYY

Please review the student's history prior to completing the form below. Students are not eligible to participate in any Hamilton College sports programs, intercollegiate, intramural and club, until this form has been completed and submitted.

**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: \_\_\_\_\_ Weight (lbs.): \_\_\_\_\_ BMI: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_ Pulse: \_\_\_\_\_

Any allergies to medication(s) / food(s)?  No  Yes/ Please list: \_\_\_\_\_

System:	Normal / Abnormal	Explain any abnormal findings:	System:	Normal / Abnormal	Explain any abnormal findings:
Skin	<input type="checkbox"/> <input type="checkbox"/>	_____	Breasts	<input type="checkbox"/> <input type="checkbox"/>	_____
HEENT	<input type="checkbox"/> <input type="checkbox"/>	_____	Abdomen	<input type="checkbox"/> <input type="checkbox"/>	_____
Neck/Thyroid	<input type="checkbox"/> <input type="checkbox"/>	_____	Neurologic	<input type="checkbox"/> <input type="checkbox"/>	_____
Lymph Nodes	<input type="checkbox"/> <input type="checkbox"/>	_____	Extremities/Joints	<input type="checkbox"/> <input type="checkbox"/>	_____
Cardiac	<input type="checkbox"/> <input type="checkbox"/>	_____	Back	<input type="checkbox"/> <input type="checkbox"/>	_____
Lungs/Chest	<input type="checkbox"/> <input type="checkbox"/>	_____	Genitourinary	<input type="checkbox"/> <input type="checkbox"/>	_____

**Tuberculosis Risk Assessment:**

If a student is high risk for exposure, documentation of a Tuberculin Skin Test (Mantoux) or a Quantiferon blood test is required within 1 year prior to arrival at Hamilton College. High risk is defined as prior contact with a person with TB; being born in Africa, Latin America, Eastern Europe or Russia; having traveled to any of these regions in the last 5 years; having lived or worked in a nursing home, prison, mental institution, homeless or HIV setting; or history of injection drug use; HIV infection, diabetes, chronic renal failure. If a TB test or a Quantiferon blood test is indicated, please complete on the immunization page.

TB Risk Assessment:  Low Risk  High Risk

Currently on any long term medications?  No  Yes / What? \_\_\_\_\_

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

Recommendations for physical activity (PE, Intramurals, Club, Collegiate): \_\_\_\_\_ Unlimited \_\_\_\_\_ Limited, Explain: \_\_\_\_\_

Health Care Provider Name: (Please Print) \_\_\_\_\_

Health Care Provider Signature: \_\_\_\_\_

Address \_\_\_\_\_

Phone: \_\_\_\_\_

or Office \_\_\_\_\_

Fax: \_\_\_\_\_

Stamp \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**HAMILTON COLLEGE Immunization Record. To be completed and signed by a health care provider.**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last Name First Name MI

New York State Public Health Law §2165 requires all students born on or after Jan. 1, 1957 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.

Enter info in MM/DD/YYYY format in English. You may attach copy of immunization record.

VACCINE	GUIDELINES	Dates Administered			
<b>MMR</b> (Measles, Mumps, Rubella combined) <b>OR:</b>	2 doses required. 1st dose no more than 4 days prior to 1st birthday and 2nd dose minimum 28 days after dose #1	Dose #1: ____/____/____			
		Dose #2: ____/____/____	or document of one of the following:	Positive Titer	Date of Disease
<b>Measles</b>	2 doses required as above if no MMR	1. ____/____/____	2. ____/____/____	#####	____/____/____
<b>Mumps</b>	2 doses required as above if no MMR	1. ____/____/____	2. ____/____/____	#####	____/____/____
<b>Rubella</b>	2 doses required as above if no MMR	1. ____/____/____	2. ____/____/____	#####	____/____/____
<b>Tetanus - Dip.</b>	Primary series with booster in last 10 years. <b>REQUIRED</b>	1. ____/____/____	2. ____/____/____	3. ____/____/____	4. ____/____/____
		5. ____/____/____	Booster: <input type="checkbox"/> Td or <input type="checkbox"/> Tdap ____/____/____		
<b>Polio</b>	Primary series <b>REQUIRED</b>	1. ____/____/____	2. ____/____/____	3. ____/____/____	4. ____/____/____
		Booster: ____/____/____			
<b>Varicella</b>	Two doses recommended if no documented history of disease	1. ____/____/____	or documentation of Positive titer: ____/____/____		
		2. ____/____/____	or history of disease date: ____/____/____		
<b>Hep B</b>	Recommended 3 dose series	1. ____/____/____	2. ____/____/____	3. ____/____/____	
		HBSAA: ____/____/____ <input type="checkbox"/> R or <input type="checkbox"/> N-R			
<b>Meningitis</b>	Recommended. <b>If not received, patient signature required on waiver to the right:</b>	1. ____/____/____	2. ____/____/____	<input type="checkbox"/> Menomune <input type="checkbox"/> Menactra <input type="checkbox"/> Menveo	
		<b>I have been informed about the risks of Meningitis and decline the immunization at this time:</b>			
		Date ____/____/____ Pt. Signature: _____			
<b>Hep A</b>	Recommended two dose series	1. ____/____/____	2. ____/____/____		
<b>HPV</b>	Recommended 3 dose series	1. ____/____/____	2. ____/____/____	3. ____/____/____	
<b>Tuberculosis</b>	Required if Student is <b>High Risk</b> <b>Send copy of chest x-ray report:</b> <b>Send copy of lab report:</b>	Placed: ____/____/____	Read ____/____/____	Result: ____mm induration	
		<b>If &gt; 10mm in duration, chest xray required.</b>			
		Date: ____/____/____ Result: _____			
		IGRA Date: ____/____/____ Please specify: <input type="checkbox"/> QFT-G <input type="checkbox"/> QFT-GIT <input type="checkbox"/> T-SPOT			
		Result: <input type="checkbox"/> NEG <input type="checkbox"/> POS <input type="checkbox"/> INDETE. <input type="checkbox"/> BORDERLINE (T-Spot ONLY)			

Health Care Provider Name: (Please Print) \_\_\_\_\_

Health Care Provider Signature: \_\_\_\_\_

Address \_\_\_\_\_  
 or  
 Office \_\_\_\_\_  
 Stamp \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_  
 Date: \_\_\_\_\_

# *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 or new health insurance information at the time of appointment;
- to keep appointments on time; or cancel appointment in a timely manner.
- to respect the Health Center policies.

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## ***We recommend that students bring the following items to college:***

- Health Insurance Card
- Thermometer
- Band-aids
- Analgesics (ie: Ibuprofen, Acetaminophen)
- Nasal Decongestants
- Cough Syrup/Cough Drops
- Tissues
- Hand Sanitizer