Emmanuel College Health Services
Entry Packet

EMMANUEL COLLEGE

Dear Incoming Undergraduate Student,

Health Services would like to welcome you to Emmanuel College. The State of Massachusetts requires that students attending college in the Commonwealth submit the required vaccinations and provide proper documentation. All forms must be completed, uploaded and entered into the Health Services Portal (see instructions below). **The deadline for submission is June 27th for Fall enrollment**

Health Services does not require a physical exam, but the 'Immunization Requirements' portion of the form should be signed by your healthcare provider. Please note that you can substitute an official vaccine record from your healthcare provider's office and an electronic signature is accepted.

The Emmanuel College Immunization & Health Form details which vaccines are required by the State of Massachusetts and those that are highly recommended by Health Services. Please make sure that your documentation includes all of the required vaccines listed or positive titers where applicable, as well as the completed Health History and TB Questionnaire. If you have not received all of the required vaccines you will need to obtain them prior to coming to campus. Health Services does not stock the state-required vaccines.

Also, please upload copies of both the front and back of your medical insurance card. We suggest students keep a picture of their insurance card in their phone.

TO SUBMIT FORMS THROUGH THE HEALTH SERVICES PORTAL PLEASE FOLLOW THE STEPS BELOW:

1. Take a picture of or scan each section of your forms and save them on your computer or phone. Do not use special characters when naming your files.
2. Navigate to the EC Health Services Portal (www.emmanuel.studenthealthportal.com) and sign in using your EC email credentials. The student health portal can be accessed on your phone and your images can be uploaded directly to your portal profile using your camera. Please note that your images may not exceed 10 MB.
3. Select 'Document Upload' and upload the documents INDIVIDUALLY to their corresponding categories found in the drop-down menu. Once completed please do not send your forms to us, but instead maintain them for your records in case there is a problem with the image quality and you need to resubmit them. Please note that it may take up to 48 business hours to fully process your form.

The Commonwealth of MA requires all students enrolled in at least 3/4 time to be enrolled in a health insurance plan. To ensure that Emmanuel College students are meeting this requirement, **all students are automatically enrolled in the College's health plan and are charged the annual health insurance premium.** If you already have coverage and would like to waive the enrollment, you must submit a 2022-2023 health insurance waiver. Students will be able to access the link to the health insurance waiver on their New Student Portal. University Health Plans (UHP) is the College's broker/plan manager and handles the enrollment and waiver process. Please call UHP at 800-437-6448 or go to www.universityhealthplans.com if you have questions about the enrollment and waiver process.

For any questions regarding the Immunization & Health Form, please contact Health Services directly at 617-264-7678 or via email at healthservices@emmanuel.edu

Thank you in advance for your cooperation and best of luck in your studies.

Sincerely,

Susan K. Benzie
Dean of Campus Life
Emmanuel College

Section 1: Contact Information and Health History (2 pages)

CONTACT INFORMATION AND HEALTH HISTORY

EMMANUEL COLLEGE

STUDENT INFORMATION

Last Name | First Name | Middle Initial

Date of Birth | Expected Graduation Year

Gender | Pronouns | Student Cell Phone Number

Home Address

City | State | Zip Code

PARENT/GUARDIAN CONTACT INFORMATION

1.

Last Name | First Name | Relationship to Student

Cell Phone Number | Work Phone Number | Email Address

2.

Last Name | First Name | Relationship to Student

Cell Phone Number | Work Phone Number | Email Address

EMERGENCY CONTACT INFORMATION

Last Name | First Name

Home Address

City | State | Zip Code

Home Phone Number | Work Phone Number

Last Name | First Name

Home Address

City | State | Zip Code

Home Phone Number | Work Phone Number

HEALTH HISTORY

Please list all past and current physical and mental health history, including COVID-19 history:

Please list all dates of prior hospitalizations (medical, psychiatric, and surgical):

Please list all current prescription & non-prescription medications including supplements/vitamins/birth control:

Please list ALL allergies including medication/food/bees/latex/seasonal and the reaction:

Do you carry an Epi-Pen? Yes_____ No _____

CONSENT FOR MEDICAL & EMERGENCY TREATMENT OF A MINOR

Student Name

This must be signed by a parent or legal guardian for students under 18 years of age.

Medical and Psychological Treatment: This is to certify that permission is granted to Emmanuel College Health Services and the Counseling Center to provide psychological treatment and medical treatment, including medication, for illness, injury or required immunizations for the above-named student.

Signature of Parent or Legal Guardian Date

Section Two: Immunization Record (1 page)

AN ELECTRONIC COPY OF YOUR IMMUNIZATION RECORD MAY BE SUBMITTED IN PLACE OF THE FOLLOWING PAGE

IMMUNIZATION RECORD (an electronic record may be submitted in place of this form)

Student Name _____ Date of Birth _____

**Proof of vaccine or immunity to MMR, Hepatitis B, Tdap, Varicella and Meningitis are REQUIRED by the State of MA. Meningitis B and HPV are strongly recommended, but not required.*

**Health Services shares information from the Entry Health Packet with the Counseling Center, Nursing Department and with Administration on a need-to-know basis.*

REQUIRED IMMUNIZATIONS	Dates Given	
COVID-19 Vaccine	Vaccine Name:_____ #1___/___/___#2___/___/___ #3___/___/___	Pfizer-BioNTech 3 doses Moderna 3 doses Johnson & Johnson's Janssen 2 dose
Hepatitis B	#1___/___/___ #2___/___/ #3___/___/_ Positive Titer HBs AB **OR** Date:___/___/_	3 doses **OR** Positive Titer Usual schedule at 0,1 & 6 months Minimum 4 weeks between doses 1 and 2 Minimum 8 weeks between doses 2 and 3 Minimum 16 weeks between 1 and 3
Meningococcal Quadrivalent **MUST BE ADMINISTERED AFTER THE AGE OF 16**	___/___/___ **Please check which vaccine administered:** Menactra___or Menveo ___ Nimenrix___**OR** signed waiver___	MENINGOCOCCAL QUADRIVALENT (A, C, Y, W-135) OR Signed Waiver (See Information about Meningococcal Disease and Waiver Form)
MMR (Measles, Mumps & Rubella Combined) Alternate: Individual vaccines or tite **Measles** **Mumps** **Rubella**	#1___/___/___ #2___/___/___ #1___/___/___ #2___/___/_ Titer Date: __/__/__ #1___/___/___ #2___/___/_ Titer Date: __/__/__ #1___/___/___ #2___/___/_ Titer Date: __/__/__	1st **dose given after 1st** birthday 2 doses - Minimum of 4 weeks between doses Positive Titers OR Individual vaccines OR Positive Titers
Tdap (Tetanus, Diphtheria, Pertussis)	Tdap ___/___/___ *If **greater than 10 yrs from date of enrollment** must provide date of recent Td___/___/_	Tdap one dose *If Tdap date is greater than 10 yrs from date of enrollment you must provide date of recent Td (tetanus,diphtheria) or Tdap booster
Varicella	#1___/___/___ #2___/___/_ Positive Titer Date / / **OR** **OR** History of disease: Yes___ No Date:___/____/____	**1st dose given after 1st** birthday 2 doses - Minimum of 4 weeks between doses **OR** Positive Titer **OR** history of disease
RECOMMENDED IMMUNIZATIONS	**DATES GIVEN**	**STANDARD DOSING**
Meningococcal Group B **MenB-4C (Bexsero)** **OR** **MenB-FHbp (Trumenba)**	#1___/___/___#2___/___/___ #1___/___/___#2___/___/___ #3 / /	2 doses at least one month apart 3 doses at 0, 2 and 6 months
Human Papillomavirus (HPV)	#1___/___/___ #2___/___/_ #3___/___/_	3 doses at 0, 2 & 6 months
Hepatitis A **OR** **Hepatitis A&B combined**	#1___/___/___ #2___/___/_ #1___/___/___ #2___/___/ #3___/___/_	Hep A: 2 doses at least 6 months apart **Hep A & B Combined:** 3 doses given on a 0, 1, and 6-month schedule

Healthcare Provider's Signature (e-signature is acceptable) Healthcare Provider's Name Date

Address Phone Number

Section Three: Meningococcal Vaccine Waiver (2 pages)

DO NOT UPLOAD THE FOLLOWING TWO PAGES IF YOU RECEIVED YOUR MENINGOCOCCAL CONJUGATE VACCINE AFTER YOUR 16TH BIRTHDAY OR YOU DO **NOT** WISH TO WAIVE THIS REQUIREMENT

Information about Meningococcal Disease, Meningococcal Vaccines, Vaccination Requirements and the Waiver for Students at Colleges and Residential Schools

Colleges: Massachusetts requires all newly enrolled full-time students 21 years of age and under attending a postsecondary institution (e.g., colleges) to: receive a dose of quadrivalent meningococcal conjugate vaccine on or after their 16th birthday to protect against serotypes A, C, W and Y **or** fall within one of the exemptions in the law, discussed on the reverse side of this sheet.

Residential Schools: Massachusetts requires all newly enrolled full-time students attending a secondary school who will be living in a dormitory or other congregate housing licensed or approved by the secondary school or institution (e.g., boarding schools) to receive quadrivalent meningococcal conjugate vaccine to protect against serotypes A, C, W and Y **or** fall within one of the exemptions in the law, discussed on the reverse side of this sheet.

The law provides an exemption for students signing a waiver that reviews the dangers of meningococcal disease and indicates that the vaccination has been declined. To qualify for this exemption, you are required to review the information below and sign the waiver at the end of this document. Please note, if a student is under 18 years of age, a parent or legal guardian must be given a copy of this document and must sign the waiver.

What is meningococcal disease?
Meningococcal disease is caused by infection with bacteria called *Neisseria meningitidis*. These bacteria can infect the tissue that surrounds the brain and spinal cord called the "meninges" and cause meningitis, or they can infect the blood or other body organs. Symptoms of meningococcal disease may appear suddenly. Fever, severe and constant headache, stiff neck or neck pain, nausea and vomiting, sensitivity to light and rash can all be signs of meningococcal disease. Changes in behavior such as confusion, sleepiness, and trouble waking up can also be important symptoms. Less common presentations include pneumonia and arthritis. In the US, about 350-550 people get meningococcal disease each year and 10-15% die despite receiving antibiotic treatment. Of those who live, another 10-20% lose their arms or legs, become hard of hearing or deaf, have problems with their nervous systems, including long term neurologic problems, or suffer seizures or strokes.

How is meningococcal disease spread?
These bacteria are passed from person-to-person through saliva (spit). You must be in close contact with an infected person's saliva in order for the bacteria to spread. Close contact includes activities such as kissing, sharing water bottles, sharing eating/drinking utensils or sharing cigarettes with someone who is infected; or being within 3-6 feet of someone who is infected and is coughing or sneezing.

Who is at most risk for getting meningococcal disease?
High-risk groups include anyone with a damaged spleen or whose spleen has been removed, those with persistent complement component deficiency (an inherited immune disorder), HIV infection, those traveling to countries where meningococcal disease is very common, microbiologists who work with the organism and people who may have been exposed to meningococcal disease during an outbreak. People who live in certain settings such as college freshmen living in dormitories and military recruits are also at greater risk of disease from some of the serogroups.

Are some students in college and secondary schools at risk for meningococcal disease?
In the 1990s, college freshmen living in residence halls were identified as being at increased risk for meningococcal disease. Meningococcal disease and outbreaks in young adults were primarily due to serogroup C. However, following many years of routine vaccination of young people with MenACWY vaccine, serogroup B is now the primary cause of meningococcal disease and outbreaks in young adults. Among the approximately 9 million students aged 18-21 years enrolled in college, there are an average of 20 cases and 2-4 outbreaks due to serogroup B reported annually.

Although incidence of serogroup B meningococcal disease in college students is low, college students aged 18-21 years are at increased risk compared to non-college students. The close contact in college residence halls, combined with certain behaviors (such as alcohol consumption, exposure to cigarette smoke, sharing food or beverages, and other activities involving the exchange of saliva), may put college students at increased risk. There is insufficient information about whether new students in other congregate living situations (e.g., residential schools) may also be at increased risk for meningococcal disease. But, the similarity in their environments and some behaviors may increase their risk.

Is there a vaccine against meningococcal disease?
Yes, there are 2 different meningococcal vaccines. Quadrivalent meningococcal conjugate vaccine (Menactra and Menveo) protects against 4 serotypes (A, C, W and Y) of meningococcal disease. Meningococcal serogroup B vaccine (Bexsero and Trumenba) protects against serogroup B meningococcal disease. Quadrivalent meningococcal conjugate vaccine is routinely recommended at age 11-12 years with a booster at age 16. Students receiving their first dose on or after their 16th birthday do not need a booster. Individuals in certain high risk groups may need to receive 1 or more of these vaccines based on their doctor's recommendations. Adolescents and young adults (16-23 years of age) who are not in high risk groups may be vaccinated with meningococcal B vaccine, preferably at 16-18 years of age, to provide short-term protection for most strains of serogroup B meningococcal disease. Talk with your doctor about which vaccines you should receive.

(see reverse side)

Is the meningococcal vaccine safe?
Yes. Getting meningococcal vaccine is much safer than getting the disease. Some people who get meningococcal vaccine have mild side effects, such as redness or pain where the shot was given. These symptoms usually last for 1-2 days. A small percentage of people who receive the vaccine develop a fever. The vaccine can be given to pregnant women. A vaccine, like any medicine, is capable of causing serious problems such as severe allergic reactions, but these are rare.

Is meningococcal vaccine mandatory for entry into secondary schools that provide housing, and colleges?
Massachusetts law (MGL Ch. 76, s.15D) and regulations (105 CMR 220.000) requires both newly enrolled full-time students attending a secondary school (those schools with grades 9-12) who will be living in a dormitory or other congregate housing licensed or approved by the secondary school or institution and newly enrolled full-time students 21 years of age and younger attending a postsecondary institution (e.g., colleges) to receive a dose of quadrivalent meningococcal conjugate vaccine.

At affected secondary schools, the requirements apply to all new full-time residential students, regardless of grade (including grades pre-K through 8) and year of study. Secondary school students must provide documentation of having received a dose of quadrivalent meningococcal conjugate vaccine at any time in the past, unless they qualify for one of the exemptions allowed by the law. College students 21 years of age and younger must provide documentation of having received a dose of quadrivalent meningococcal conjugate vaccine on or after their 16th birthday, regardless of housing status, unless they qualify for one of the exemptions allowed by the law. Meningococcal B vaccines are not required and do not fulfill the requirement for receipt of meningococcal vaccine. Whenever possible, immunizations should be obtained prior to enrollment or registration. However, students may be enrolled or registered provided that the required immunizations are obtained within 30 days of registration.

Exemptions: Students may begin classes without a certificate of immunization against meningococcal disease if: 1) the student has a letter from a physician stating that there is a medical reason why he/she can't receive the vaccine; 2) the student (or the student's parent or legal guardian, if the student is a minor) presents a statement in writing that such vaccination is against his/her sincere religious belief; or 3) the student (or the student's parent or legal guardian, if the student is a minor) signs the waiver below stating that the student has received information about the dangers of meningococcal disease, reviewed the information provided and elected to decline the vaccine.

Shouldn't meningococcal B vaccine be required?
CDC's Advisory Committee on Immunization Practices has reviewed the available data regarding serogroup B meningococcal disease and the vaccines. At the current time, there is no routine recommendation and no statewide requirement for meningococcal B vaccination before going to college (although some colleges might decide to have such a requirement). As noted previously, adolescents and young adults (16 through 23 years of age) *may* be vaccinated with a serogroup B meningococcal vaccine, preferably at 16 through 18 years of age, to provide short term protection against most strains of serogroup B meningococcal disease. This would be a decision between a healthcare provider and a patient. These policies may change as new information becomes available

Where can a student get vaccinated?
Students and their parents should contact their healthcare provider and make an appointment to discuss meningococcal disease, the benefits and risks of vaccination, and the availability of these vaccines. Schools and college health services are not required to provide you with this vaccine.

Where can I get more information?
- Your healthcare provider
- The Massachusetts Department of Public Health, Division of Epidemiology and Immunization at (617) 983-6800 or www.mass.gov/dph/imm and www.mass.gov/dph/epi
- Your local health department (listed in the phone book under government)

Waiver for Meningococcal Vaccination Requirement

I have received and reviewed the information provided on the risks of meningococcal disease and the risks and benefits of quadrivalent meningococcal conjugate vaccine. I understand that Massachusetts' law requires newly enrolled full-time students at secondary schools who are living in a dormitory or congregate living arrangement licensed or approved by the secondary school, and newly enrolled full-time students at colleges and universities who are 21 years of age or younger to receive meningococcal vaccinations, unless the students provide a signed waiver of the vaccination or otherwise qualify for one of the exemptions specified in the law.

☐ After reviewing the materials above on the dangers of meningococcal disease, I choose to waive receipt of meningococcal vaccine.

Student Name:_____ Date of Birth:_____ Student ID: _____

Signature:_____ Date: _____
(Student or parent/legal guardian, if student is under 18 years of age)

Section Four: Tuberculosis Questionnaire (3 pages)

YOU DO NOT NEED TO UPLOAD PAGES TWO OR THREE IF YOU ANSWERED "NO" TO ALL OF THE QUESTIONS ON PAGE ONE

TUBERCULOSIS QUESTIONNAIRE (MANDATORY)

EMMANUEL COLLEGE

Student Name

PART 1: TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE (to be completed by parent/incoming student)

Please refer to this list of countries/territories below when responding to the questions below.

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
China, Hong Kong SAR
China, Macao SAR
Colombia
Comoros
Congo
Cote d'Ivoire
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Eswatini
Ethiopia
Fiji
French Polynesia
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mexico
Micronesia (Federated States of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Qatar
Republic of Korea (South Korea)
Republic of Moldova
Romania
Russian Federation
Rwanda
Sao Tome and Principe
Senegal
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Tajikistan
Thailand
Timor-Leste
Togo
Tokelau
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

Source: World Health Organization, Tuberculosis Incidence 2020

Please answer the following questions:

1.	Did you ever receive a BCG vaccine as a child?	☐ Yes	☐ No
2.	Have you ever had close contact with persons known or suspected to have active TB disease?	☐ Yes	☐ No
3.	Have you ever had a history of a positive PPD skin test?	☐ Yes	☐ No
4.	Were you born in one of the countries or territories listed above that have a high incidence of active TB disease? (If yes, please CIRCLE the country)	☐ Yes	☐ No
5.	Are you a recent arrival (<5 years) from one of the high prevalence areas listed above? If YES please indicate date of arrival: / /	☐ Yes	☐ No
6.	Have you had frequent or prolonged visits (for more than one month) to one or more of the countries or territories listed above with a high prevalence of TB disease? (If yes, CIRCLE the country/countries)	☐ Yes	☐ No
7.	Have you been a health care worker, volunteer, resident and/or employee of high-risk congregate settings or served clients who are at increased risk of active TB disease (e.g., correctional facilities, long-term care facilities, homeless shelter, substance abuse treatment, rehabilitation facility)?	☐ Yes	☐ No
8.	Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease – medically underserved, low income or abusing drugs or alcohol?	☐ Yes	☐ No

IF YOU ANSWERED NO TO ALL THE ABOVE QUESTIONS, no further testing is required (and no need to complete parts 2 and 3 of the TB Questionnaire).

IF THE ANSWER IS YES TO ANY OF THE ABOVE QUESTIONS, Emmanuel College requires that you receive TB testing as soon as possible, but at least prior to the start of the semester. Have your healthcare providercomplete and return pages 2 & 3 of the Tuberculosis (TB) Questionnaire.

*The significance of the travel exposure should be discussed with a health care provider and evaluated.

PART 2: CLINICAL ASSESSMENT BY HEALTHCARE PROVIDER

Clinicians should review and verify the information in Part I. Persons answering YES to any of the questions in Part I are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented.

History of a positive TB skin test or IGRA blood test? (If yes, document below) Yes_____ No _____

History of BCG vaccination? (If yes, consider IGRA if possible.) Yes_____ No _____

1. TB Symptom Check

   Does the student have signs or symptoms of active pulmonary tuberculosis disease? Yes_____No _____

   If No, proceed to 2 or 3

   If yes, check below :

   - ❑ Cough (especially if lasting for 3 weeks or longer) with or without sputum production
   - ❑ Coughing up blood (hemoptysis)
   - ❑ Chest pain
   - ❑ Loss of appetite
   - ❑ Unexplained weight loss
   - ❑ Night sweats
   - ❑ Fever

   Proceed with additional evaluation to exclude active tuberculosis disease including chest x-ray (PA and lateral) and sputum evaluation as indicated.

2. Interferon Gamma Release Assay (IGRA)

   Date Obtained:_____/_____/_____ (specify method) QFT -GIT T-Spot other.....
   M D Y

   Result: negative___ positive___ indeterminate___ borderline___ (T-Spot only)

   Date Obtained: _____/_____/_____ (specify method) QFT-GIT T-Spot other.....
   M D Y

   Result: negative___ positive___ indeterminate___ borderline___ (T-Spot only)

3. Tuberculin Skin Test (TST)

   (TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0". The TST interpretation should be based on mm of induration as well as risk factors.)**

   Date Given: _____/_____/_____ Date Reac:_____/_____/_____
   M D Y M D Y

   Result: ____mm of induration **Interpretation: positive_____negative_____

   Date Given: _____/_____/_____ Date Reac:_____/_____/_____
   M D Y M D Y

   Result: ____mm of induration **Interpretation: positive_____negative_____

**Interpretation guidelines

> 5 mm is positive:

- Recent close contacts of an individual with infectious TB
- persons with fibrotic changes on a prior chest x-ray, consisten1with past TB disease
- organ transplant recipients and other immunosuppressed persons (including receiving equivalent of >15 mg/d of prednisone for >1 month.)
- HIV- infected persons

>10 mm is positive:

- Foreign born or travelers to the U.S. from high prevalence areas or who resided in one for a significant * amount of time
- injection drug users
- mycobacteriology laboratory personnel
- residents, employees, or volunteers in high- risk congregate settings
- persons with medical conditions that increase the risk of progression to TB disease including silicosis, diabetes mellitus, chronic renal failure, certa in types of cancer (leukemias and lymphomas, cancers of the head, neck, or lung), gastrectomy or jejunoileal bypass and weight loss of at least 10% below ideal body weight.

>15 mm is positive:

- persons with no known risk factors for TB who, except for certain testing programs required by law or regulation, would otherwise not be tested .

* The significance of the travel exposure should be discussed with a health care provider and evaluated .

4. Chest x-ray : (Required if IGRA or TST is positive . Note: a single PA view is indicated in the absence of symptoms)

Date of chest x-ray: ____ /____/__ _ Result: normal_____abnormal____

M D Y

PART 3. MANAGEMENT OF POSITIVE IGRA OR TST

In deciding whether to recommend treatment of LTBI to individual patients, the clinician should weigh the likelihood of infect ion, the likelihood of progression to act ive tuberculosis infection, and the benefit of therapy. Students in the following groups are at increased risk of progression from LTBI to active TB disease and should be prioritized to begin treatment as soon as possible.

- ☐ Infected with HIV
- ☐ Recently infected with M. tuberculosis (within the past 2 years)
- ☐ History of untreated or inadequately treated TB disease, including persons with fibrotic changes on chest radiograph consistent with prior TB disease
- ☐ Receiving immunosuppressive therapy such as tumor necrosis factor-alpha (TNF) antagonists , systemic Cortico steroids equivalent to/greater than 15 mg of prednisone per day, or immunosuppressive drug therapy following organ transplantation
- ☐ Diagnosed with silicosis, diabetes mellitus, chronic renal failure, leukemia, or cancer of the head, neck, or lung
- ☐ Have had a gastrectomy or Jejunoileal bypass
- ☐ Weigh less than 90% of their ideal body weight
- ☐ Cigarette and e-cigarette smokers and persons who abuse drugs and/or alcohol

Section Five: Consent For Treatment and Privacy Practices (7 Pages)

CONSENT FOR TREATMENT

EMMANUEL COLLEGE

Student Name | Date of Birth

The following Consent for Treatment is to be carefully reviewed and then acknowledged by the student or, if the student is under the age of 18, by a legally authorized parent/representative.

I hereby authorize the staff of Health Services to examine and treat me during my enrollment at Emmanuel College. However, I understand that I may be responsible for other charges including, but not limited to, lab tests, imaging, allergy injections and immunizations. I understand that some costs may not be covered by my medical insurance and that I may need a referral from my Primary Care Provider (PCP) in order to receive care at Health Services and it is my responsibility to confirm this prior to receiving care at Health Services. I agree to pay for chargeable services as they are incurred. I authorize my insurance provider to pay for any covered services rendered in relation to medical treatment provided through Health Services at Emmanuel College. I understand that an Explanation of Benefits (EOB) may be sent to the primary insurance subscriber (my parents) which may contain details of services provided.

I understand that Health Services may collaborate with the Counseling Center in providing medical and mental health care to me. I authorize the staff of both services to discuss my health information, unless otherwise noted below.

___ Check here if you allow the Health Services staff to discuss your care with the Counseling Center when medically indicated.

___Yes, I consent to treatment, and acknowledge my responsibilities, as indicated above.

Signature of Student (if 18 or older)/Parent or representative (if under 18) | Date

If parent/representative, please indicate your relationship to student

Instruction A: Insert the covered entity's name

Instruction B: Insert the covered entity's address, web site and privacy official's phone, email address, and other contact information.

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective March 16, 2022

This Notice of Privacy Practices applies to the following organizations.

Emmanuel College Student Health Services

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

EMMANUEL COLLEGE

I understand, and have been provided with, the Notice of Privacy Practices that provides a more complete description of medical information use and disclosures.

I understand that I have the right to review the notice prior to signing this acknowledgement form and may request a copy for my own records.

I understand that Health Services reserves the right to change their notice and practices and that change will be posted in the office and available to me on the Health Services website.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that Health Services is not required to agree to the restrictions requested.

I understand that I may revoke this acknowledgement in writing, except to the extent the organization has already taken action.

Student Name | Student ID Number

Signature of patient or legal representative | Date

If parent/representative, please indicate your relationship to student

Please do not forget to upload images of the front **and** back of your insurance card!