



## COLLEGE HEALTH SERVICES

Maura Marshall, ARNP, MSN, Director  
100 Saint Anselm Drive, Manchester, New Hampshire 03102 • www.anselm.edu  
Phone: 603-641-7029 • Fax: 603-641-7318

June, 2009

Dear New Student:

I would like to take this opportunity to welcome you to Saint Anselm College on behalf of College Health Services. We are housed in the Holistic Health Center located in the lower level of Cushing Center. We offer a full service clinic, counseling services, and health education to all of our students.

Our philosophy is based on the “wellness” of each student. Our goal is to support you as you continue your personal growth and education at Saint Anselm. Please feel free to come by our offices and meet with the Registered Nurses, Nurse Practitioners and Counselors.

Enclosed you will find your copy of the **College Health Services Philosophy and Mission statement, Admission Health Report** which includes the **Immunization History, Medical Emergency Permission Form, Informed Consent, Student Bill of Rights**. All students (*even commuters*) must complete and sign all of the pages as indicated and bring the Physical Examination Form and Immunization History to your physician to be completed as he/she does your physical. Please be sure your physician fills in specific dates of communicable diseases (i.e. measles, rubella, etc.) and immunizations, as we need this information to be in compliance with NH state law.

**Please Note: physical exam should have been done within one (1) year of entrance to college except varsity athletes who need their physical to be done within six (6) months of the start of their first tryout.** If non athletes have insurance that does not allow a physical until a later date, please have the physician fill out the most recent physical data and return this to us and provide us with the updates as soon as the new physical is completed in the fall semester.

Return all forms in the enclosed envelope provided to College Health Services by **Friday, July 24, 2009.** **Please be aware that failure to provide medical information will result in the inability to register for fall classes.**

We look forward to seeing you soon.

Sincerely,

Maura Marshall, ARNP, MSN  
Director, College Health Services

**REQUIRED OF ALL STUDENTS- Please answer all questions & keep a copy of these pages for your record.**
**TEL (603) 641-7028  
 FAX (603) 641-7318**

 This information is strictly **CONFIDENTIAL** and will be used as an aid to provide necessary health care while you are a student. Information supplied will become a part of your health record, will not influence your standing at the College, and will not be released to anyone except by your written authorization.

RETURN COMPLETED FORM TO:

**HEALTH SERVICES, SAINT ANSELM COLLEGE, 100 SAINT ANSELM DRIVE (#1722), MANCHESTER, NH. 03102-1310**

 NAME \_\_\_\_\_ DOB \_\_\_\_\_  
 Last / First / Middle Initial \_\_\_\_\_  
 Students Cell # \_\_\_\_\_

PARENT'S NAMES or Legal Guardian \_\_\_\_\_

 Home Address \_\_\_\_\_  
 Street \_\_\_\_\_ City / State / Zip \_\_\_\_\_

Home tele# \_\_\_\_\_

Mom's work # \_\_\_\_\_ Dad's work # \_\_\_\_\_

Mom's cell # \_\_\_\_\_ Dad's cell # \_\_\_\_\_

 Emergency Notification if different from above \_\_\_\_\_  
 Name / relationship / Phone # \_\_\_\_\_

 CLASS:  Fr.  So.  Jr.  Sr.  Other SEX:  M  F MARITAL STATUS: \_\_\_\_\_ CITIZEN USA:  Yes or \_\_\_\_\_ (Name Other)  
 To live on campus \_\_\_\_\_ or commuter \_\_\_\_\_

**Your (student's) PAST OR PRESENT HISTORY OF: (Circle if any issues have pertained to YOU and explain below)**

Anemia	Dizziness / Fainting / Blackouts	Intestinal Problems	Sexually Transmitted Diseases
Anxiety	Drug or Alcohol Issues	Joint Disease	Sickle Cell Disease / Trait
Asperger's Disorder	Eating Disorder	Kidney Disease	Skin Disorders
Asthma / Lung Disorders	Emotional Problems	Learning Disability	Sleep Issues
Bi-polar Disorder	Epilepsy / Convulsions	Leukemia	Staphylococcal Infection / MRSA
Bleeding abnormal	Head Injury / Concussion	Migraine headaches	Stomach Problems
Cancer & / Impaired Immunity	Hearing Loss	Mononucleosis	Thyroid Disorder
Chicken Pox	Heart Disease or Murmurs	Orthopaedic Injuries	Weight Issues
Depression	Hepatitis	Schizophrenia	NONE OF THE ABOVE
Diabetes	HIV Infections/AIDS	Seizures	

 EXPLAIN ALL / & or OTHER: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**CURRENT MEDICATION** by prescription or over the counter (List includes birth control pills, herbal and sport related supplements)

 \_\_\_\_\_  
 \_\_\_\_\_

**ALLERGIC** to (circle) \_\_\_\_\_ medicine nuts bees/wasps trees/pollen dust/mold latex

 If food or medication, please list with your reaction \_\_\_\_\_  
 \_\_\_\_\_

Should you have an epi-pen for use if necessary? Yes or No Do you have one? Yes or No

 Will you need allergy desensitization therapy? Yes or No If yes, **bring serum** and signed schedule from your home physician

sleep \_\_\_\_\_ hours a night

current weight \_\_\_\_\_ lbs :: ideal weight as you would like to see \_\_\_\_\_ lbs. Hospitalizations \_\_\_\_\_

Dietary needs \_\_\_\_\_ Surgeries \_\_\_\_\_

Menstrual Cycle: frequency \_\_\_\_\_ duration \_\_\_\_\_ problems \_\_\_\_\_

Have you received mental health services In-patient Yes or No or Out-patient Yes or No

Please explain \_\_\_\_\_

Do you plan to try out for a varsity sport? Yes or No Which sport(s) \_\_\_\_\_

**Note physical exam requirements: NCAA mandates a sport's history and physical on any athlete within 6 months from date of 1<sup>st</sup> sport tryout.**

Permission is granted to release information to the Athletic Training Department if I participate in a varsity sport. \_\_\_\_\_ Signature

**FAMILY HISTORY**::: Circle if ANY OF YOUR BLOOD RELATIVES HAVE or HAD - grandparents, parents, siblings, and blood aunt(s) and uncle(s) -

	<b>RELATION</b>		<b>RELATION</b>
Allergies	_____	Epilepsy/Convulsions	_____
Alcoholism/Drug Abuse	_____	Familial Disease	_____
Asthma	_____	Heart Disease	_____
Autism	_____	Intestinal Problems	_____
Bleeding, abnormal	_____	Kidney Disease	_____
Bi-polar disease	_____	Lung Disease/TB	_____
Bone disorders / osteoporosis	_____	Migraine Headache	_____
Cancer and/or impaired immunity	_____	Stomach Problems	_____
Depression / Suicide	_____	Schizophrenia	_____
Diabetes	_____	Please indicate if you are adopted	_____

Or None of the Above \_\_\_\_\_

Any family member died before the age of 55, list with cause of death \_\_\_\_\_

FAMILY HISTORY	AGE	STATE OF HEALTH	CAUSE OF DEATH (if applicable)	AGE AT DEATH	FAMILY HISTORY	AGE	STATE OF HEALTH	CAUSE OF DEATH (if applicable)	AGE
Father					Sibling				
Mother					Sibling				
Sibling					Sibling				
Sibling					Sibling				

Primary Care Physician \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Office Tel.# \_\_\_\_\_ Fax Tel.# \_\_\_\_\_

**INSURANCE INFORMATION: (PLEASE STAPLE COPY OF BOTH SIDES OF INSURANCE CARD TO THIS FORM)**

NAME OF INSURANCE: \_\_\_\_\_ HMO:  Yes  No PPO:  Yes  No

SUBSCRIBER'S NAME \_\_\_\_\_ INS. TELE # \_\_\_\_\_

POLICY NO.: \_\_\_\_\_ GROUP NO.: \_\_\_\_\_

I hereby authorize Saint Anselm College Health Services to provide routine examinations, diagnosis and treatment. I acknowledge that Saint Anselm College contracts with and makes referrals to outside independent laboratories/health care providers which will be billed to the students' medical insurance. I agree to release Saint Anselm College, its professional health care providers and employees from any and all liability arising from any such referrals or contracted services. I understand that Saint Anselm College complies with NH State Public Health regulations and is required to report certain positive lab results to public health agencies.

In the event of an emergency, I hereby give my permission to be treated & transported to the closest emergency facility for appropriate medical treatment. I give permission for Saint Anselm personnel to release pertinent medical/insurance information to that emergency facility and if necessary to notify my emergency contact listed above.

I hereby certify the information on this form is complete to the best of my knowledge

Signature of Student \_\_\_\_\_ Date \_\_\_\_\_

And/or \_\_\_\_\_ Date \_\_\_\_\_

Parent or Guardian if student is under 18 years

**PHYSICAL EXAMINATION**

(by your medical provider)

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sport Participation \_\_\_\_\_

<p style="text-align: center;">PE ON EVERY STUDENT (WITHIN 1 YEAR FROM START OF SCHOOL)</p> <p>BP _____ P _____                  Weight _____ Height _____ BMI _____                  Visual Acuity:                  R _____ L _____ With or without corrective lenses</p> <p>MENTAL/EMOTIONAL STATUS _____                  SKIN _____                  HEENT _____                  NECK, THYROID _____                  LUNGS _____                  CARDIO (Murmur, Pulses) _____                  ABDOMEN _____                  EXTREMITIES / SPINE _____                  NEUROLOGICAL _____                  UROGENITAL(optional) _____                  PERTINENT PAST MEDICAL HISTORY _____                  _____                  CURRENT MEDICATIONS: _____                  _____                  ALLERGIES TO MEDICINE/FOOD/OTHER? _____                  _____</p>	<p style="text-align: center;">MANDATORY SPORTS PE ON ANY ATHLETE WITHIN 6 MONTHS FROM DATE OF 1<sup>ST</sup> SPORT TRYOUT</p> <p><b>HISTORY; Please circle if +</b> Prior exertional chest pain, exertional syncope or /near syncope                  Excessive, unexplained shortness of breath or fatigue with exercise                  Prior history of heart murmur or increased blood pressure                  Family history of premature death from cardiovascular disease in a relative younger than age 50 or unexplained sudden death.</p> <p><b>Occurrence in family of hypertrophic cardiomyopathy, dilated cardiomyopathy, long QT syndrome or Marfan's syndrome Yes or No</b></p> <p>Explain with dates                  Concussions, head inj _____                  Sport injuries _____                  Surgeries _____                  CT scan/ MRI's _____</p> <p style="text-align: center;"><b>SPORT SECTION ON PHYSICAL EXAM (MANDATORY)</b></p> <p>BRACHIAL BP _____                  PRECORDIAL AUSCULTATION – SUPINE/STANDING _____                  HEART (MURMUR, DYSRHYTHMIA?) _____                  FEMORAL ARTERY PULSES _____                  RECOGNITION OF MARFAN'S SYNDROME _____                  HERNIA (males) _____                  LMP (females) _____ ANY IRREGULARITIES _____                  MUSCULORSKELETAL: ROM/ strength/ laxity _____</p> <p>ANY RESTRICTIONS ON SPORTS PARTICIPATION _____                  Date of this exam _____</p>
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**IMMUNIZATON HISTORY (with dates) ALL REQUIRED ON EVERY STUDENT**  
 Provider please read! Some info not on your immunization sheets

Year of chickenpox disease \_\_\_\_\_ or Varivax \_\_\_\_\_

**TB RISK** (circle) Low or High: if high risk or international student **REQUIRED** Mantoux within 30 days from start of college.

Result \_\_\_\_\_ mm. date \_\_\_\_\_ If (+) CXR required result \_\_\_\_\_ and treatment plan \_\_\_\_\_

**POLIO** (circle IPV or OPV) \_\_\_\_\_

**TETANUS, Diphtheria, Pertussis series** \_\_\_\_\_  
 Td \_\_\_\_\_ Tdap \_\_\_\_\_

**MMR** \_\_\_\_\_

**HEPATITIS B** \_\_\_\_\_

**MENINGOCOCCAL MCV4** \_\_\_\_\_

**OTHER: (Optional) – Hepatitis A, Gardasil, Pneumovax**

Signature of provider \_\_\_\_\_ Date of this exam \_\_\_\_\_

Tel.# \_\_\_\_\_

Fax# \_\_\_\_\_



ATTENTION

ATTENTION

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**MANAGED CARE  
INSURANCE INFORMATION  
(HMO, PPO, etc.)**

All Saint Anselm students are  
REQUIRED  
to carry health insurance.

If your son or daughter will be covered by an HMO while a student at St. Anselm College, please be advised that many HMO's refuse to pay for non-emergency medical care by physicians who are not employed by their health care plan. This may necessitate that your son/daughter **return home** for care in the case of an illness that is not an emergency. Also, medications are not usually covered if the medication is ordered by a Nurse Practitioner or Physician outside their plan.

**Medicaid from any state other than New Hampshire does not cover the student for expenses incurred in New Hampshire.**

Your son/daughter needs to be aware of exactly what steps need to be followed in order to insure that your HMO will pay for out-of-area care in non-emergency and emergency situations and medications ordered by Campus Health Services Staff/Consultants.

The staff at Health Services will do all that we can to insure that your son/daughter notifies the proper person regarding out-of-area charges for medical care, but ultimately costs incurred will be the parents' responsibility. It is important for the student to know the proper procedures for obtaining authorization for payment from his/her HMO provider.

NOTE: **INSURANCE INFORMATION**

**WILL BE MAILED TO YOU OVER THE SUMMER.  
ADDITIONAL COPIES MAY BE OBTAINED FROM THE  
*TREASURER'S OFFICE.***

You will be billed for College Student Accident and Health Insurance  
unless you return the  
WAIVER/ENROLLMENT CARD with proof of insurance.

*(This will be mailed to you in July under separate cover.)*

# **SAINT ANSELM COLLEGE HEALTH SERVICES**

## ***PHILOSOPHY AND MISSION STATEMENT***

In support of the educational mission of Saint Anselm College, the philosophy of College Health Services is based on a holistic view of the individual person. The goal of the College Health Service is to maximize the potential of each individual student physically, emotionally, spiritually, intellectually, occupationally, and socially.

Following the philosophy of holistic health, we strive to encourage each student to accept the responsibility of active participation in attaining/maintaining his/her health.

Utilizing the three dimensions of College Health – Medical, Counseling, and Education – our mission is to assist the student through lifestyle assessment, health care, counseling, and health teaching to make responsible life choices which impact future health and well-being and lead to an integrative balance of all aspects of the self.

Because our approach is multidisciplinary, when an issue has both medical and counseling components, our staff members confer with one another to better coordinate student care.

Information shared in a counseling or clinic session is privileged (confidential), is **not** part of the student's academic record, and will not be disclosed to any party outside of the Health Service without your prior **written consent**. Only professional staff and administrative assistant have access to records.

Should a client wish information forwarded to other parties, we will provide verbal or written reports to a professional that is designated, once we have obtained **written permission** to do so. Confidentiality will be broken **only** if such disclosure is (a) necessary to protect a client or someone else from imminent physical danger; (b) in cases of apparent child or elder abuse; or (c) in those rare instances when records are legally court ordered. Such exceptions to a client's right of privilege are mandated by New Hampshire State law. In these cases, certain college officials will also be notified and the client will be apprised of this notification.

### **Counseling Health Service Information Guide**

1. Counseling is free of charge within the Health Service Department. The Counseling service requires that a 24 hour notice be given if the client is unable to keep a scheduled appointment. Failure to notify the counseling service of the need to cancel or reschedule an appointment may result in the client being assessed a charge of \$10.00. Should this fee go unpaid, it would be added to the client's Health Service bill as a miscellaneous medical expense.

2. Counseling services are available Monday through Friday on a regular schedule. In the case of an emergency please contact your Resident Assistant or Resident Director and if necessary, go to the nearest emergency room. Catholic Medical Center is located at 100 McGregor Street Manchester, N.H.

I understand and am in agreement with the above:

\_\_\_\_\_  
Please sign your name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print your name

\_\_\_\_\_  
Witnessed

SAINT  
ANSELM  
COLLEGE



**TO:** All non-resident Students

**FROM:** Maura Marshall, ARNP, MSN  
*Director, Campus Health Services*

**RE:** **OPTIONAL NON-RESIDENT MEDICAL FACILITIES FEE**  
**(FOR THOSE STUDENTS NOT PAYING ROOM AND BOARD)**

The medical facilities of the campus Health Services are available not only to resident students, but also to those non-resident students who wish to take advantage of them for a fee of **\$100.00 per academic year or \$50.00 per semester.**

If your son or daughter will be living off campus, he/she will need to pay an off campus fee to receive **non-emergency** care at Health Services. (This fee is considered part of Room and Board for those students living on campus). This is a yearly fee and entitles the student to all the services provided by Health Services, including weekly clinics staffed by a physician; or nurse practitioner; or registered nurse evaluation and assessment.

Health Services is open during the following hours:

**Please refer to Health Services Brochure or web site for hours of operation.**

In addition, a physician will be available at posted hours, weekly.

If you choose to take this option, please complete the form below and return it to the Office of College Health Services with a check for \$100.00, made payable to: **Saint Anselm College.**

*Please note that this fee is not mandatory.*

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**NON-RESIDENT MEDICAL FACILITIES REGISTRATION**

NAME \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_

I wish to take advantage of the medical facilities of the Saint Anselm College Health Services as a **non-resident student** and I enclose the fee of \_\_\_\_\_ .

Signed \_\_\_\_\_

Date \_\_\_\_\_

*Please make check payable to:*  
**SAINT ANSELM COLLEGE**

*Please return this form and check to:*  
**OFFICE OF COLLEGE HEALTH SERVICES  
SAINT ANSELM COLLEGE - #1722  
MANCHESTER, NH 03102-1310**

**RESIDENTIAL CARE AND HEALTH FACILITY LICENSING**  
**PATIENTS' BILL OF RIGHTS**  
**Section 151:21**

**151:21 Patients' Bill of Rights.** – *The policy describing the rights and responsibilities of each patient admitted to the facility shall include, as a minimum, the following:*

- I. The patient shall be treated with consideration, respect, and full recognition of the patient's dignity and individuality, including privacy in treatment and personal care and including being informed of the name, licensure status, and staff position of all those with whom the patient has contact, pursuant to RSA 151:3-b.
- II. The patient shall be fully informed of a patient's rights and responsibilities and of all procedures governing patient conduct and responsibilities. This information must be provided orally and in writing before or at admission, except for emergency admissions. Receipt of the information must be acknowledged by the patient in writing. When a patient lacks the capacity to make informed judgments the signing must be by the person legally responsible for the patient.
- III. The patient shall be fully informed in writing in language that the patient can understand, before or at the time of admission and as necessary during the patient's stay, of the facility's basic per diem rate and of those services included and not included in the basic per diem rate. A statement of services that are not normally covered by Medicare or Medicaid shall also be included in this disclosure.
- IV. The patient shall be fully informed by a health care provider of his or her medical condition, health care needs, and diagnostic test results, including the manner by which such results will be provided and the expected time interval between testing and receiving results, unless medically inadvisable and so documented in the medical records, and shall be given the opportunity to participate in the planning of his or her total care and medical treatment, to refuse treatment, and to be involved in experimental research upon the patient's written consent only. For the purposes of this paragraph "health care provider" means any person, corporation, facility, or institution either licensed by this state or otherwise lawfully providing health care services, including, but not limited to a physician, hospital or other health care facility, dentist, nurse, optometrist, podiatrist, physical therapist, or psychologist, and any officer, employee, or agent of such provider acting in the course and scope of employment or agency related to or supportive of health care services.
- V. The patient shall be transferred or discharged after appropriate discharge planning only for medical reasons, for the patient's welfare or that of other patients, if the facility ceases to operate, or for nonpayment for the patient's stay, except as prohibited by Title XVIII or XIX of the Social Security Act. No patient shall be involuntarily discharged from a facility because the patient becomes eligible for Medicaid as a source of payment.
- VI. The patient shall be encouraged and assisted throughout the patient's stay to exercise the patient's rights as a patient and citizen. The patient may voice grievances and recommend changes in policies and services to facility staff or outside representatives free from restraint, interference, coercion, discrimination, or reprisal.
- VII. The patient shall be permitted to manage the patient's personal financial affairs. If the patient authorizes the facility in writing to assist in this management and the facility so consents, the assistance shall be carried out in accordance with the patient's rights under this subdivision and in conformance with state law and rules.
- VIII. The patient shall be free from emotional, psychological, sexual and physical abuse and from exploitation, neglect, corporal punishment and involuntary seclusion.
- IX. The patient shall be free from chemical and physical restraints except when they are authorized in writing by a physician for a specific and limited time necessary to protect the patient or others from injury. In an emergency, restraints may be authorized by the designated professional staff member in order to protect the patient or others from injury. The staff member must promptly report such action to the physician and document same in the medical records.

- X. The patient shall be ensured confidential treatment of all information contained in the patient's personal and clinical record, including that stored in an automatic data bank, and the patient's written consent shall be required for the release of information to anyone not otherwise authorized by law to receive it. Medical information contained in the medical records at any facility licensed under this chapter shall be deemed to be the property of the patient. The patient shall be entitled to a copy of such records, for a reasonable cost, upon request.
- XI. The patient shall not be required to perform services for the facility. Where appropriate for therapeutic or diversional purposes and agreed to by the patient, such services may be included in a plan of care and treatment.
- XII. The patient shall be free to communicate with, associate with, and meet privately with anyone, including family and resident groups, unless to do so would infringe upon the rights of other patients. The patient may send and receive unopened personal mail. The patient has the right to have regular access to the unmonitored use of a telephone.
- XIII. The patient shall be free to participate in activities of any social, religious, and community groups, unless to do so would infringe upon the rights of other patients.
- XIV. The patient shall be free to retain and use personal clothing and possessions as space permits, provided it does not infringe on the rights of other patients.
- XV. The patient shall be entitled to privacy for visits and, if married, to share a room with his or her spouse if both are patients in the same facility and where both patients consent, unless it is medically contraindicated and so documented by a physician. The patient has the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, including choice of room and roommate, except when the health and safety of the individual or other patients would be endangered.
- XVI. The patient shall not be denied appropriate care on the basis of race, religion, color, national origin, sex, age, disability, marital status, or source of payment, nor shall any such care be denied on account of the patient's sexual orientation.
- XVII. The patient shall be entitled to be treated by the patient's physician of choice, subject to reasonable rules and regulations of the facility regarding the facility's credentialing process.
- XVIII. The patient shall be entitled to have the patient's parents, if a minor, or spouse, or next of kin, or a personal representative, if an adult, visit the facility, without restriction, if the patient is considered terminally ill by the physician responsible for the patient's care.
- XIV. The patient shall be entitled to receive representatives of approved organizations as provided in RSA 151:28.
- XX. The patient shall not be denied admission to the facility based on Medicaid as a source of payment when there is an available space in the facility.

**Source. Off. Jan. 1, 1999; 388:5, 6.**

I have read the entire **Bill of Rights** above:

Signed \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

*IF A MINOR (under 18) PARENT(S) OR LEGAL GUARDIAN(S) MUST SIGN ALSO.*

Signed \_\_\_\_\_ Relationship \_\_\_\_\_

Print Name \_\_\_\_\_



**TO:** All New Students

**FROM:** Maura Marshall, ARNP, MSN, Director, Campus Health Services

**RE:** HEALTH RELATED ITEMS TO BRING WITH YOU TO COLLEGE

**Ace Bandage**

**Antibiotic cream** (Ex. Neosporin) for cuts etc.

**Band-Aids**

**Cold medicine** you usually use (antihistamine, decongestant etc.)

**Cough medicine**

**Gatorade (dry mix package)**

**Hand sanitizer**

**Hydrocortisone cream** (Ex. Cortaid) for itch, rash

**Pepto Bismol** (or other antacid for nausea, diarrhea, upset stomach)

**Reusable cold/hot pack** (can be used in both microwave oven and/or freezer)

**Scissors**

**Thermometer** (small digital readout; ***not*** mercury)

**Throat Lozengers**

**Tweezers**

**Tylenol/Ibuprofen/Advil etc.**

***STUDENTS WITH ASTHMA - Please bring:***

**Nebulizer**

**Peak flow meter**

***STUDENTS WITH ADD/ADHD - Please bring:***

**A lock box/safe or some way to secure your Concerta, Adderal etc. to keep it safe.**