HEALTH SERVICES ADMISSION REQUIREMENTS 2019-20

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 located on the lower level of the Roger and Francine Jean Student Center. We offer a full service medical clinic, counseling services, and health education to all of our students.
Per state requirements, we need to have health records on file for you to attend classes and live on campus.
The first priority is to access your St. A's e-mail. If you have any difficulty, call the Help Desk
(603) 222-4295.

Health Services has the following requirements of new students: **Due Date- January 12, 2020**
All forms should be completed and uploaded to the Health Services Patient Portal
http://patient-anselm.medicatconnect.com

1. **Admission Health Report Form:** includes immunization history, medical emergency permission form, and informed consent. **(*You can complete or download and mail, fax or email)***
2. **Physical Exam and Immunization History (*Completed by medical provider, upload to Patient Portal or mail, fax or email)* Varsity Athletes must submit health form to both Athletics and Health Services.**

Please Note: physical exam should have been completed after January 12, 2019, within a 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. Please notify us if you need a physical because your insurance does not cover it within the time period.

3. **3rd Millennium Classroom:** Freshmen and Transfer students are **required** to complete the online alcohol & sexual violence prevention program prior to January 12th https://web.3rdmil.com/ Start ASAP
4. **Health Insurance: Health Services needs a copy of your card. (upload to Patient Portal or mail, fax or email)** *Complete on-line Waiver if you would like to opt out of the Student Health Insurance.* All Saint Anselm students are **required** to carry health insurance. A student accident and health insurance program is offered to students. **You will be automatically billed for College Student Accident and Health Insurance unless you complete the online waiver by January 13th.** If you do not wish to purchase the plan offered through the college, it is very important that you access the Web site at www.gallagherstudent.com/saintanselm

5. **Philosophy & Mission and Bill of Rights – Read Only**
6. **Commuters:** The medical facilities of the campus Health Services are available to non-resident students for a fee of **$100.00 per academic year or $50.00 per semester**.

Return all forms to College Health Services by **January 12th, 2020**. **Please be aware that failure to provide medical information may result in the inability to move in to campus, attend classes, or register for classes.**

We look forward to seeing you soon.
Sincerely,
Maura Marshall, APRN, MSN
Director, College Health Services
mmarshall@anselm.edu
(603) 641-7028

HEALTH SERVICES

TEL (603) 641-7028
FAX (603) 641-7318

SAINT ANSELM COLLEGE

ADMISSION HEALTH REPORT FORM

Please answer all questions & keep a copy of these pages for your record

This information is strictly **CONFIDENTIA**L 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, (#1722) 100 SAINT ANSELM DRIVE, MANCHESTER, NH 03102-1310

NAME_____DOB _____
Last / First / Middle Initial

Home Address _____
Street City / State / Zip

Student's Cell # _____ Home Tel# _____

PARENTS' NAMES or Legal Guardian (LG): _____

Mom's work #_____ Dad's work #_____ LG(Wk#) _____

Mom's cell # _____ Dad's cell # _____ LG(Cell#)_____

Emergency Notification if different from above _____
Name / Relationship / Phone #

International Students – Emergency Contact in the USA: _____

CLASS: ❒Fr. ❒So. ❒Jr. ❒Sr. ❒RN/BSN SEX: ❒M ❒F MARITAL STATUS: _____ CITIZEN USA: ❒Yes or (Name Other)

To live on campus _____ or commuter_____

Do you plan to try out for a varsity sport? Yes or No _____ List sport(s):
_____

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

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

_____ **Signat**
Signature of Student (if under 18, Parent of Student)

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

ADD/ADHD	Diabetes	HIV Infections/AIDS	Seizures
Anemia	Dizziness / Fainting / Blackouts	Intestinal Problems	Sexually Transmitted Diseases
Anxiety	Drug or Alcohol Issues	Joint Disease	Sickle Cell Disease / Trait
Asperger's Disorder/Autism/PDD	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	Missing Organs	Thyroid Disorder
Chicken Pox	Heart Disease or Murmurs	Mononucleosis	Weight Issues
Contact Lenses	Heat Stroke/Exhaustion	Orthopaedic Injuries	NONE OF THE ABOVE
Depression	Hepatitis	Schizophrenia	

EXPLAIN ALL / & or OTHER: _____

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

ALLERGIES TO:	Will you need allergy desensitization therapy? Yes or No If yes, **bring serum and signed schedule from your home physician.**	**Should you have an epi-pen for use if necessary?** Yes or No Do you have one? Yes or No

TUBERCULOSIS SCREENING QUESTIONNAIRE RISK FACTOR:

Have you ever had a positive tuberculin skin test in the past? YES ❑ NO ❑	Were you born outside of the US? YES ❑ NO ❑ Country
Have you ever had close contact w/anyone who was sick with tuberculosis (TB)? YES ❑ NO ❑	Have you ever spent significant time in a country outside of the U.S.? YES ❑ NO ❑ Country

Sleep _____hours a night

Current Weight: _____ lbs. Ideal Weight as You would like to be _____lbs. Hospitalizations:

_____

Dietary needs: _____ Surgeries:

_____

Menstrual Cycle: Frequency _____ Duration_____ Problems_____

Have you ever lost your Period for a prolonged period of time? ____ Please explain:_____

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

Please explain:_____

Name _____ Sport _____

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

	RELATION		**RELATION**
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 # _____

SUBSCRIBER'S DOB _____ EFFECTIVE DATE OF POLICY _____

POLICY NO.: _____ GROUP NO.: _____

I hereby authorize Saint Anselm College Health Services and the Athletic Training Department 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 student's 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 that a I am referred to an outside provider I authorize that provider to provide Saint Anselm College Athletic Training and Health Services copies of my office notes and /or medical records.

In the event of an emergency, I hereby give my permission to be treated and 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. Withholding or falsifying information can result in immediate loss of playing status, or other sanctions deemed by the Department of Athletics, if applicable.

I have read, understand, and agree with the Saint Anselm College Health Services Philosophy and Mission Statement. I have read and received a copy of the Residential Care and Health Facility Licensing Patients Bill of Rights (see Admissions Portal or Health Services Webpage/freshman forms)

Signature of Student_____ _____
Date_____
And/or Parent or Guardian if student is under 18 years _____ Date_____

Saint Anselm College

PHYSICAL EXAMINATION

(by your medical provider)

Name: _____Date of Birth: _____ Sport(s) Participation: _____

*****PE ON EVERY STUDENT*****

(WITHIN 1 YEAR FROM START OF SCHOOL)

*******NCAA RULING - MANDATORY SPORTS PE ON ANY ATHLETE WITHIN 6 MONTHS FROM DATE OF 1ST SPORT TRYOUT*******

BP _____ P _____ Weight _____ Height _____ BMI _____

Visual Acuity: R_____ L _____ With or without corrective lenses

MENTAL/EMOTIONAL STATUS _____

SKIN _____

HEENT _____

NECK, THYROID _____

LUNGS _____

CARDIO (Murmur, Pulses, Dysrhythmia) _____

Precordial auscultation – Supine/Standing _____

ABDOMEN _____

Femoral artery pulses _____

EXTREMITIES / SPINE _____

Musculoskeletal: ROM / strength / laxity _____

NEUROLOGICAL _____

UROGENITAL _____

Hernia (males) _____

LMP (females)_____ ANY IRREGULARITIES _____

PERTINENT PAST MEDICAL HISTORY_____

CURRENT MEDICATIONS:_____

ALLERGIES TO MEDICINE / FOOD / OTHER? _____

HISTORY: Please circle if + 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.

Occurrence in family of hypertrophic cardiomyopathy, dilated cardiomyopathy, long QT syndrome or Marfan's syndrome YES or NO

*****Sickle Cell trait _____ Date Tested/Waived_____ Family history of Sickle Cell Anemia

***REQUIRED FOR PARTICIPATION IN ANY NCAA VARSITY SPORT AS A FRESHMAN OR TRANSFER STUDENT**

SPORTS INJURIES: Explain with dates

Concussion/Head Injuries/"Bellrung"_____	Shoulders _____	Hips _____
Time missed _____	Elbows _____	Knees _____
Surgeries _____	Wrists _____	Ankles_____
Back_____	Hands _____	Feet_____
Neck_____	Fingers _____	Toes _____

ANY RESTRICTIONS ON SPORTS PARTICIPATION? _____ **Date of this exam** _____

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# _____**

3rd Millennium Classroom
Alcohol-Wise and Consent & Respect
Mandatory Online Alcohol and Healthy Relationship Course
Must be completed before moving in to campus

Dear New Student,
As part of our comprehensive program, Saint Anselm **requires** each incoming freshman to complete **Alcohol-Wise**, an online alcohol prevention program, and **Consent & Respect**, information about healthy relationships, prior to moving on to campus.
Whether you drink or not, Alcohol-Wise and Consent & Respect will empower you to make well-informed decisions and will help you cope with the behavior of your peers.
The courses take approximately one hour to complete. You may log into the course as many times as needed to finish the course. You do not have to complete it in one sitting. You must earn a score of 70 or higher to receive credit. **Deadline for Completion: January 12th, 2020**
***If you participated in an alcohol/sexual violence course at a prior institution, please provide that paperwork to Health Services ***
To get started on the course, go to the 3rd Millennium Classrooms website at www.3rdmil.com
At the Student Login area, use the following username/password:
Email: **Use your Saint Anselm Email Address**
Password: **Class2023**
Once you're logged into the course, click "Start Course."
After you arrive on campus, you will be required to complete Part 2. You will receive a reminder via email.
***Sanctions for non-completion include a $100 fine and alcohol violation on your record.**
For technical questions, please contact info@3rdmil.com or call #888-810-7990
Good luck with the course!

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 $50.00. 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.

Your signature on the Admission Health Report Form represents your understanding and agreement with the above.

04/2017

TITLE XI
HOSPITALS AND SANITARIA

CHAPTER 151
RESIDENTIAL CARE AND HEALTH FACILITY LICENSING
Patients' Bill of Rights

Section 151:21

151:21 Patients' Bill of Rights. –

[Introductory paragraph effective until January 1, 2014; see also introductory paragraph set out below.]

The policy describing the rights and responsibilities of each patient admitted to the facility shall include, as a minimum, the following:

[Introductory paragraph effective January 1, 2014; see also introductory paragraph set out above.]

The policy describing the rights and responsibilities of each patient admitted to a facility, except those admitted by a home health care provider, 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 record, 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 upon request. The charge for the copying of a patient's medical records shall not exceed $15 for the first 30 pages or $.50 per page, whichever is greater; provided, that copies of filmed records such as radiograms, x-rays, and sonograms shall be copied at a reasonable cost.

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.

XIX. 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.

XXI. Subject to the terms and conditions of the patient's insurance plan, the patient shall have access to any provider in his or her insurance plan network and referral to a provider or facility within such network shall not be unreasonably withheld pursuant to RSA 420-J:8, XIV.

Source. 1981, 453:1. 1989, 43:1. 1990, 18:1-6; 140:2, XI. 1991, 365:10. 1992, 78:1. 1997, 108:6; 331:3-8. 1998, 199:2; 388:5, 6. 2001, 85:1, eff. Aug. 18, 2001. 2009, 252:1, eff. Sept. 14, 2009. 2013, 265:3, eff. Jan. 1, 2014.

Your signature on the Admission Health Report Form indicates that you have read and received a copy of the **Bill of Rights**.

04/2017

http://www.gencourt.state.nh.us/rsa/html/XI/151/151-21.htm 11/21/2013

TO: All non-resident Students

FROM: Maura Marshall, APRN, MSN
Director, College Health Services

RE: ***OPTIONAL FOR COMMUTERS*** **NON-RESIDENT MEDICAL FACILITIES FEE**

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.

- -

NON-RESIDENT MEDICAL FACILITIES REGISTRATION

NAME ____

STUDENT ID 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