COMPLETE HEALTH HISTORY PACKET
Must be completed by the student (parent/guardian)
and/or a health care provider

About Wellness Services

The Wellness Center at Roberts Wesleyan University provides comprehensive wellness programming to RWU students, including health services, counseling services, and wellness education and prevention programming. The Wellness Center is committed to providing quality, compassionate, and equitable care that is individualized to students' needs. We emphasize self-responsibility and encourage students to take an active role in maintaining their health and wellbeing.

HEALTH & IMMUNIZATION REQUIREMENTS MUST BE SUBMITTED BY THE FOLLOWING DATES:

Fall Semester - July 1st
Spring Semester - December 15th

*Failure to submit required information may prevent you from being cleared for residence, class attendance, and sports participation.

New York State Public Health Law 2165 mandates ALL students enrolled at institutions of higher education ARE REQUIRED to provide evidence of vaccination against measles, mumps, and rubella, if born on or after January 1, 1957. For more information about MMR requirements please visit
https://www.health.ny.gov/prevention/immunization/schools/toolkit/sample_nys_phl_section_2165_imm_requirements.pdf

New York State Public Health Law 2167 mandates ALL students, regardless of age, to provide proof of meningococcal vaccine (dated within 5 years) or a signed declination statement. For more information about meningitis vaccination requirements please visit https://www.health.ny.gov/prevention/immunization/handbook/section_9_appendices/appendix_a/public_health_law/article_21/title_6/section_2167.htm

Per New York State Public Health Law: No institution should permit any student to attend the institution in excess of 30 days without complying.

REQUIREMENTS FOR ALL STUDENTS

1. Required Immunizations (MMR, Meningitis) **Supporting documentation required. You may use the provided form along with a physician's signature OR provide an official copy of your immunization history from your doctor's office.*
2. Health History Form
3. Consent for Treatment & Emergency Services

ADDITIONAL REQUIREMENTS - INTERNATIONAL STUDENTS

1. Tuberculosis (TB) screening questionnaire
2. Proof of active health insurance

ADDITIONAL REQUIREMENTS - ATHLETES

1. Physical examination (dated no earlier than 6 months prior to starting sports participation)
2. Sickle Cell test results
3. Proof of active health insurance

ADDITIONAL REQUIREMENTS - NURSING STUDENTS IN CLINICAL

- Physical examination (dated within 1 year of clinical placement).
- Tuberculosis (TB) screening, varicella vaccination, annual flu/covid vaccination/declination, hepatitis B vaccination/declination, current Basic Life Support (BLS) certification, active health insurance
- See Nursing Department for details about vaccinations and attestations required for your program prior to clinical placement.

Complete forms and upload all health and immunization requirements through the Student Health Portal. Go to: Roberts.studenthealthportal.com, use your Roberts email address & password to log in. Please contact the Wellness Center with any questions.

HEALTH HISTORY / SPORTS PRE-PARTICIPATION

**To be completed by ALL students*

Section 1: To be Completed by Student

Name: ____ Gender: ___________ Birthdate: _____/_____/_____

Cell Phone: ____________________ Home Phone: ____________________ Email: ____________________

Circle: FR SO JR SR Sport(s): ____

MEDICAL

1.	Have you had a medical illness (particularly a severe viral or flu-like illness) or injury since your last checkup or sports physical?	☐ YES	☐ NO
2.	Have you had infectious mononucleosis ("mono")?	☐ YES	☐ NO
3.	Do you have any ongoing/chronic medical illnesses (diabetes, heart condition, etc.)?	☐ YES	☐ NO
4.	Do you have asthma?	☐ YES	☐ NO
5.	Do you have trouble breathing, cough, or wheeze during or after exercise?	☐ YES	☐ NO
6.	Have you been hospitalized overnight? *If so, please describe on back*	☐ YES	☐ NO
7.	Have you seen a doctor because of an injury	☐ YES	☐ NO
8.	Have you had surgery? *If so, please describe on back*	☐ YES	☐ NO

MEDICATIONS/SUPPLEMENTS: (Last 12 Months Only)

9.	Are you regularly taking any medications (prescription or non-prescription) or using an inhaler? PLEASE INCLUDE BIRTH CONTROL, ADDERALL/RITALIN *If so, please describe on back*	☐ YES	☐ NO
10.	Have you been diagnosed with attention deficit disorder (ADD)? NOTE: THE NCAA REQUIRES DOCUMENTATION OF FORMALL ADD TESTING	☐ YES	☐ NO
11.	Are you presently taking vitamins, supplements to gain or lose weight, or supplements to aid performance? ALL SUPPLEMENT USE MUST BE REPORTED	☐ YES	☐ NO

ALLERGIES: (Last 12 Months Only)

12.	Do you have any allergies to medications, pollens, foods, or stinging insects?	☐ YES	☐ NO
13.	Have you developed a rash or hives during or after exercise?	☐ YES	☐ NO

HEART

14.	Have you had chest pain during or after exercise? *If so, please describe on back*	☐ YES	☐ NO
15.	Have you been told that you have a heart murmur?	☐ YES	☐ NO
16.	Have you "passed out" during or after exercise	☐ YES	☐ NO
17.	Have you felt dizzy during or after practice or competition?	☐ YES	☐ NO
18.	Do you tire more quickly with exertion than your teammates?	☐ YES	☐ NO
19.	Have you been diagnosed with high blood pressure or high cholesterol?	☐ YES	☐ NO
20.	Have you had an electrocardiogram (EKG), echocardiogram (sound wave test of the heart), or been evaluated by a heart specialist?	☐ YES	☐ NO
21.	Have you had severe or repeated racing of your heart or skipped heartbeats?	☐ YES	☐ NO
22.	Has anyone in your family died of heart problems or of sudden death before age 50?	☐ YES	☐ NO
23.	Has a physician denied or restricted your athletic participation for any reason? *If so, please describe*	☐ YES	☐ NO

NEUROLOGIC

24.	Have you had a head injury or concussion? *If so, please describe on back*	☐ YES	☐ NO
25.	Have you been "knocked out," lost consciousness, or lost memory?	☐ YES	☐ NO
26.	Have you had a seizure?	☐ YES	☐ NO
27.	Do you suffer from frequent or severe headaches, particularly with exercise?	☐ YES	☐ NO
28.	Have you had a "stinger," "burner," or pinched nerve?	☐ YES	☐ NO
29.	Have you experienced numbness or tingling in your arm, hands, legs, or feet after being hit or falling?	☐ YES	☐ NO

Continued on next page

ROBERTS WESLEYAN UNIVERSITY

HEALTH HISTORY / SPORTS PRE-PARTICIPATION

**To be completed by ALL students*

ORTHOPAEDIC

Question	YES	NO
30. Have you had broken bones, dislocations, sprains or tendonitis that caused you to miss a practice or game?	☐ YES	☐ NO
31. Have you had a stress fracture?	☐ YES	☐ NO
32. Do you use any special equipment (braces, neck rolls, eye guards, orthotics, etc.)?	☐ YES	☐ NO

NUTRITION: (Last 12 Months Only)

Question	YES	NO
33. Do you have concerns about your EATING HABITS or have you been diagnosed with an EATING DISORDER or IRON DEFICIENCY/ANEMIA?	☐ YES	☐ NO
34. Do you want to weigh more or less than you do?	☐ YES	☐ NO
35. Do you lose weight regularly to meet the weight requirements/demands of your sport?	☐ YES	☐ NO
36. Do you often skip meals or strictly limit/control what you eat?	☐ YES	☐ NO

MISCELLANEIOUS

Question	YES	NO
37. Have you or a family member been diagnosed with SICKLE CELL DISEASE/TRAIT?	☐ YES	☐ NO
38. When exercising in the heat, do you have severe muscle cramps or become ill?	☐ YES	☐ NO
39. Have you been diagnosed with depression, anxiety, or panic attacks?	☐ YES	☐ NO
40. Have you had any skin problems (acne, warts, herpes, etc.)?	☐ YES	☐ NO
41. Have you had any trouble with your eyes or vision?	☐ YES	☐ NO
42. Do you wear contact lenses/glasses?	☐ YES	☐ NO

FOR WOMEN ONLY

1. At what age was your first menstrual period? ___________________________________
2. When was your last menstrual period? ____
3. What was the longest time between periods last year? _____________________________
4. How many menstrual periods did you have in the last 12 months? ___________________
5. Have you previously or are you now on birth control medication? ___________________

List all medications and supplements:

____

____

____

Explain any "YES" answer below:

____

____

____

List any additional comments about your medical history:

____

____

To the best of my knowledge, I hereby state that my answers to the above questions are accurate.

____ ______ / ______ / ______

Signature of student Date

____ ______ / ______ / ______

Signature of parent/guardian if student is under 18 Date

Student athletes MUST complete Section 2 to meet NCAA requirements

ROBERTS WESLEYAN UNIVERSITY

PHYSICAL EXAMINATION

**REQUIRED for student athletes*
**Not required for traditional students, but recommended*

Section 2: To be completed by physician or qualified health provider

Student Information	
Name:	**Date of Birth:**
Intercollegiate Sport(s)	**Gender:**
Date of Physical	**Year in School: FR SO JR SR**

Examination **Athletic physical must be dated within 6 months of sports participation *Nursing physical within 1 year of clinical work*

Height:	**Weight:**	**BP:**	**Pulse:**	**BMI:**

Vision Corrected: ☐ Yes ☐ No L 20/ R 20/ **Pupils: Equal / Unequal**

	Normal	**Abnormal or significant findings**
General		
Appearance		
HEENT		
Lung		
Hearth Murmurs (auscultation standing, supine)		
Endocrine/Lymph Nodes		
Abdominal		
Genialia (males only)		
Pulses Radial pulses & simultaneous femoral		
Neurologic		
Skin		
Musculoskeletal		
Neck/Shoulder/Back		
Arm/Elbow/Wrist/Hand/Fingers		
Leg/Hip/Thigh/Knee		
Ankle/Foot/Toes		

Does the student have drug allergies? If yes, please list by name and type of reaction: ____

____

____

Recommendations/Comments regarding the chronic condition or serious illness continuing care of the student:

____

____

Comments/Concerns regarding student's emotional wellness: ____

____

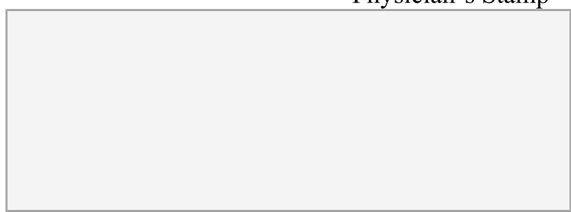
❒ Cleared to participate in a full program college study
❒ Cleared for all sports without restrictions
❒ Cleared for all sports without restriction, with recommendations for further evaluation or treatment for ______________________
❒ Not cleared for sports
❒ Not cleared for college study
❒ Pending further evaluation

Reason and recommendations: ____

____

Medical provider signature/stamp or a copy of the medical provider's document must be attached.

Physician's Stamp



______________________________ ____________
MD, NP, or PA's Signature Date

____
MD, NP, or PA's Printed Name

____
Address, City, State

What is meningococcal disease?

Meningococcal disease is caused by bacteria called Neisseria meningitidis. It can lead to a serious blood infection called meningococcal septicemia. When the linings of the brain and spinal cord become infected, it is called meningococcal meningitis. The disease strikes quickly and can have serious complications, including death.

Anyone can get meningococcal disease. Some people are at higher risk. This disease occurs more often in people who are:

- Teenagers or young adults
- Infants younger than one (1) year of age
- Living in crowded settings, such as college dormitories or military barracks
- Traveling to areas outside of the United States, such as the "meningitis belt" in Africa
- Living with a damaged spleen or no spleen or have sickle cell disease
- Living with HIV
- Being treated with the medication Soliris® or Ultomiris™, or those who have complement component deficiency (an inherited immune disorder)
- Exposed during an outbreak
- Working with meningococcal bacteria in a laboratory
- Recently infected with an upper respiratory virus
- Smokers

What are the symptoms?

Symptoms appear suddenly – usually three (3) to four (4) days after a person is infected. It can take up to ten (10) days to develop symptoms. Symptoms of meningococcal meningitis may include:

- Fever
- Headache
- Stiff neck
- Nausea
- Vomiting
- Photophobia (eyes being more sensitive to light)
- Altered mental status (confusion)

Newborns and babies may not have the classic symptoms listed above, or it may be difficult to notice those symptoms in babies. Instead, babies may be slow or inactive, irritable, vomiting, feeding poorly, or have a bulging anterior fontanelle (the soft spot of the skull). In young children, doctors may also look at the child's reflexes for signs of meningitis.

Symptoms of meningococcal septicemia may include:

- Fever and chills
- Fatigue (feeling tired)
- Vomiting
- Cold hands and feet
- Severe aches or pains in the muscles, joints, chest, or abdomen (belly)
- Rapid breathing
- Diarrhea
- In the later stages, a dark purple rash

How is meningococcal disease spread?

It spreads from person-to-person by coughing or coming into close or lengthy contact with someone who is sick or who carries the bacteria. Contact includes kissing, sharing drinks, or living together. Up to one (1) in 10 people carry meningococcal bacteria in their nose or throat without getting sick.

Is there treatment?

Early diagnosis of meningococcal disease is very important. If it is caught early, meningococcal disease can be treated with antibiotics. However, sometimes the infection has caused too much damage for antibiotics to prevent death or serious long-term problems. Most people need to be cared for in a hospital due to the serious, life-threatening nature of this infection.

What are the complications?

10-15% of those who get meningococcal disease die. Among survivors, as many as one (1) in five (5) will have permanent disabilities.

Complications include:

- Hearing loss
- Brain damage
- Kidney damage
- Nervous system problems
- Limb amputations

What should I do if I or someone I love is exposed?

If you are in close contact with a person with meningococcal disease, talk with your healthcare provider about the risk to you and your family. They can prescribe an antibiotic to prevent the disease.

What is the best way to prevent meningococcal disease?

The single best way to prevent this disease is to be vaccinated. Vaccines are available for people six (6) weeks of age and older. Various vaccines offer protection against the five (5) major strains of bacteria that cause meningococcal disease:

- All preteens and teenagers should receive two doses of vaccine against strains A, C, W and Y, also known as MenACWY or MCV4 vaccine. The first dose is given at 11 to 12 years of age, and the second dose (booster) at 16 years. It is very important that teens receive the booster dose at age 16 years in order to protect them through the years when they are at greatest risk of meningococcal disease.
- Teens and young adults can also be vaccinated against the "B" strain, also known as MenB vaccine. Talk to your healthcare provider about whether they recommend vaccine against the "B" strain.

Who should not be vaccinated?

Some people should avoid or delay the meningococcal vaccine:

- Tell your doctor if you have any severe allergies. Anyone who has ever had a severe allergic reaction to a previous dose of meningococcal vaccine should not get another dose of the vaccine.
- Anyone who has a severe allergy to any component in the vaccine should not get the vaccine.
- Anyone who is moderately or severely ill at the time the shot is scheduled should wait until they are better. People with a mild illness can usually get vaccinated.

What are the meningococcal vaccine requirements for school attendance?

- For students entering grades seven (7) through 11: one dose of MenACWY vaccine
- For students entering grade 12: two (2) doses of MenACWY vaccine
    - The second dose needs to be given on or after the 16th birthday.
    - Teens who received their first dose on or after their 16th birthday do not need another dose.

Additional Resources:

Meningococcal Disease – Centers for Disease Control and Prevention (CDC) [https://www.cdc.gov/meningococcal/]
Meningococcal Vaccination – CDC [https://www.cdc.gov/vaccines/vpd/mening/]
Meningococcal ACIP Vaccine Recommendations [https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/mening.html]
Travel and Meningococcal Disease [https://wwwnc.cdc.gov/travel/diseases/meningococcal-disease]
Information about Vaccine-Preventable Diseases [https://www.health.ny.gov/prevention/immunization/]

ROBERTS WESLEYAN UNIVERSITY

MENINGOCOCCAL VACCINATION RESPONSE FORM

New York State Public Health Law requires that all college and university students enrolled for at least six (6) semester hours or the equivalent per semester, or at least four (4) semester hours per quarter, complete and return the following form to the Roberts Wesleyan University Wellness Center.

The Advisory Committee on Immunization Practices recommends that all first-year college students up to 21 years of age have at least 1 dose of Meningococcal ACWY (MenACWY) vaccine (Brand names: Menactra, Menveo) not more than 5 years before enrollment, preferably on or after the 16th birthday.

Young adults 16 through 23 years of age may choose to receive the Meningococcal B (MenB) vaccine series (Brand names: Trumenba, Bexsero). College and university students should discuss the MenB vaccine with a healthcare provider.

Check one box and sign below.

I have (for students under the age of 18 years refers to the parent or legal guardian) received and reviewed the information regarding meningococcal disease.

- ☐ I (My child) had meningococcal immunization (MenACWY and/or MenB) within the past 5 years. The vaccine record is attached.
- ☐ I (My child) will obtain meningococcal immunization **within 30 days** from my private health care provider, the Monroe County Health Department, or other health facility.
- ☐ I understand the risks of meningococcal disease and the benefits of immunization at the recommended ages. I have decided that I (my child) will **not** obtain immunization against meningococcal disease at this time.

____ ____________________
Student Signature or Parent/Guardian if student is less than 18 — Date

____ ____________________
Student Name (Print) — Student Birthdate

____ ____________________
Student E-mail Address — Student ID#

____
Student Mailing Address

(______)____
Student Phone Number

Please note: Roberts Wesleyan University does **not** offer the meningitis vaccine. You can receive this vaccine from your health care provider or the Monroe County Health Department, which offers vaccines by appointment. For an appointment or information about immunizations through the Health Department, please call (585) 753-5150.

ROBERTS WESLEYAN UNIVERSITY

IMMUNIZATION REQUIREMENTS

Must be completed by ALL students.

Supporting documentation and/or physician signature/stamp is required.

Student's Name____ **Date of Birth** _____/_____/______

1. **NYS Public Health Law 2165 mandates** students born after January 1, 1957 **enrolled in six (6) credit hours or more per semester** provide documented proof of immunity (vaccines or titer (blood) test results) against measles, mumps, and rubella.

   MMR #1 (Measles, Mumps, Rubella) Date: _____/_____/_____

   MMR #2 (Measles, Mumps, Rubella) Date: _____/_____/_____

   OR Documentation of immunity to measles, mumps, and rubella by separate vaccines or (blood) titer tests

   Measles 1 Date: _____/_____/_____ **or** Positive/Immune Measles Titer Date: _____/_____/_____

   Measles 2 Date: _____/_____/_____

   Mumps Date: _____/_____/_____ **or** Positive/Immune Mumps Titer Date: _____/_____/_____

   Rubella (German measles) Date: _____/_____/_____ **or** Positive/Immune Rubella Titer Date: _____/_____/_____

2. **NYS Public Health Law 2167 mandates** ALL students, regardless of age, to provide proof of the meningococcal meningitis vaccine or a signed declination statement. Please complete: **MENINGOCOCCAL VACCINATION RESPONSE FORM**.

3. The following vaccinations are **not** required but are recommended by the CDC for adults between the ages of 19 and 26:

   - Chickenpox vaccine (varicella) [https://www.cdc.gov/vaccines/vpd/varicella/public/index.html]
   - COVID-19 vaccine [https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html]
   - Flu vaccine (influenza) [https://www.cdc.gov/vaccines/vpd/flu/index.html]
   - Hepatitis B vaccine [https://www.cdc.gov/vaccines/vpd/hepb/index.html]
   - HPV vaccine (human papillomavirus) [https://www.cdc.gov/hpv/index.html]
   - Tdap vaccine (Tetanus, diphtheria, and whooping cough) [https://www.cdc.gov/vaccines/vpd/pertussis/index.html#vacc] or Td (tetanus, diphtheria) [https://www.cdc.gov/vaccines/vpd/tetanus/index.html]

4. Tuberculosis (TB) screening is required for international students, nursing students (prior to clinical placement), and students at high risk due to travel, exposure, or other reasons. PLEASE COMPLETE: **TUBERCULOSIS (TB) SCREENING FORM.**

ATHLETES ONLY! Sickle Cell testing is required for all NCAA athletes. Please provide proof of testing and results.

New York State screens all infants for sickle cell disease/trait as part of the Newborn Screening panel. The following options are available for obtaining sickle cell disease/trait status:

- Obtain a lab order from your health care provide and have a blood test
- Contact your pediatrician or birth hospital for results
- Have your current health care provider request NYS newborn screening results from the Newborn Screening Program
- Request a copy of your own results from the Newborn Screening Program. Students over 18 or parent/guardians of students under 18 can visit the following website for instruction and to access the request form: https://www.wadsworth.org/programs/newborn/screening/providers/obtaining-results

Students who are currently NYS residents but who were not born in NYS should contact the newborn screening program in the State they were born for results.

Please attach supporting documentation OR medical provider signature/stamp

____ ___________

MD, NP, or PA's Signature Date

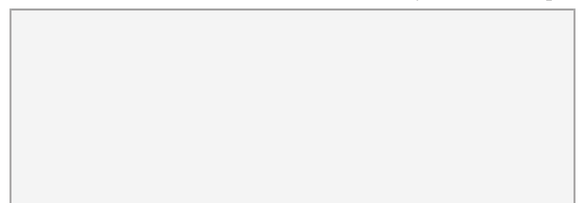
____

MD, NP, or PA's Printed Name

____

Address, City, State

Physician's Stamp



ROBERTS
WESLEYAN UNIVERSITY

TUBERCULOSIS (TB) SCREENING
**Required for international students, nursing students & students at high risk*

Tuberculosis (TB) Screening Questions

❑ Yes ❑ No Have you ever had close contact with persons known or suspected to have active TB disease?

❑ Yes ❑ No Have you ever had close contact with anyone who was sick with TB?

❑ Yes ❑ No Were you born outside of the United States? If yes, please CIRCLE the country below:

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
China, Hong Kong SAR
China, Macao SAR
Colombia
Comoros
Congo
Côte 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
Kyrgyzstan
Lao People's Democratic Republic
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
Niue
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Qatar
Republic of 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
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Vietnam
Yemen
Zambia
Zimbabwe

**High-burden TB countries are countries with TB incidence rates of ≥ 20 cases per 100,000 population. High-burden country data obtained from 2023 WHO Global Tuberculosis Report and reflects 2022 data.*

❑ Yes ❑ No Have you had frequent or prolonged visits* to one or more of the countries/territories above with a high prevalence of TB disease? (If yes, CHECK the countries/territories). **The significance of the travel exposure should be discussed with a health care provider and evaluated.*

❑ Yes ❑ No Have you been a resident, volunteer, and/or employee of any high-risk congregate settings (e.g., correctional facilities, long-term care facilities, homeless shelters)?

❑ Yes ❑ No Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease?

❑ Yes ❑ No Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease - medically underserved, low-income, or abusing drugs or alcohol?

IF THE ANSWER TO ALL QUESTIONS ABOVE IS NO, NO FURTHER TESTING OR ACTION IS REQUIRED.

IF THE ANSWER IS YES TO ANY OF THE ABOVE QUESTIONS
Roberts Wesleyan University requires that you receive TB testing as soon as possible but at least prior to the start of the subsequent semester. If you have already had a TB test done, please provide supporting medical documentation of the results and/or chest x-ray.

If you have had any other testing or have been treated for TB, please contact the Wellness Center at (585) 594-6360 for instruction.

______________________________________ __________________________________
Signature of student (or parent/guardian if less than 18) **Date**

ROBERTS WESLEYAN UNIVERSITY

CONSENT FOR TREATMENT & EMERGENCY SERVICES

**Required for ALL traditional undergraduate students*

The Wellness Center offers medical services (provided by NY State licensed practitioners) and mental health services (provided by NY State licensed practitioners, and limited permit holders and graduate students under licensed supervision) to all eligible students. The Wellness Center does not bill insurance or collect payment for any services or point of care testing performed on-site.

HEALTH SERVICES

Available health services include basic medical care, testing, evaluation, treatment, and recommendation, as deemed advisable by the medical provider. No guarantee or assurance will be made as to the results of medical treatment or examination. On occasion a reference lab is used for testing that cannot be completed on-site. These services are separate from the Wellness Center and subject to insurance and/or fees from the lab/facility. The Wellness Center may share allergy and/or immunization information with relevant entities on campus (i.e. registrar, student life, academic affairs, athletics) on a need-to-know basis, as determined by the University.

COUNSELING SERVICES

Available counseling services include urgent care/crisis counseling, consultation, individual, and group counseling. A detailed informed consent is provided to any student wishing to engage in routine counseling. Urgent care/crisis counseling visits typically consist of assessment by a staff counselor, intervention, safety-planning, and recommendation for follow-up care. Although rare, the counselor may determine a higher level of care or alternative treatment may be clinically appropriate to address immediate needs or safety. This may include (but is not limited to), a request for welfare check, referral for mobile crisis intervention, and/or contacting 911. Occasionally, a counselor may communicate with a Residence Director and/or Campus Safety officer on a limited, need-to-know-basis, to ensure student safety. Student privacy and confidentiality are a priority whenever essential collaboration must take place.

CONFIDENTIALITY AND PRIVACY PRACTICES

All information provided to the Wellness Center is confidential. Written permission is required to release any information to other parties except as allowable by law for treatment and healthcare operations. Situations where we may use or disclose protected health information about you without your written permission includes:

- Where required by county, state or federal law (danger to self or others, subpoena by court due to civil or criminal litigation, legally required morbidity reporting to public health officials).
- In the event of an emergency, medical or counseling staff may provide, coordinate, and manage health care and related services. This may include coordinating and communicating with other health care providers regarding your medical/psychiatric history and securing transportation to a higher level of care.
- If a student is under 18 years of age, we may disclose medical information to a parent, guardian, or other person responsible for the minor except in circumstances when law protects such information.
- For the purposes of obtaining medication history when using an electronic system to process prescriptions for treatment

PHOTOGRAPHY AND AUDIO/VIDEO RECORDING IS PROHIBITED AT ALL TIMES.

AUTHORIZATION FOR EMERGENCY MEDICAL SERVICES OR TREATMENT

I voluntarily give consent to Roberts Wesleyan University and its agents or representatives, to obtain and authorize emergency medical and/or dental treatment as is necessary to protect my/my child's health and well-being. This includes first aid measures, contacting Emergency Medical Services (EMS), authorization for emergency treatment, anesthesia, and/or surgery as deemed necessary. I consent to Roberts Wesleyan University disclosing any and all of my medical information in its possession for the sole purpose of assessing my medical needs or obtaining medical services on my behalf. I agree to be held responsible for all necessary charges incurred by any hospitalization or treatment rendered pursuant to this authorization.

I hereby release and agree to hold harmless Roberts Wesleyan University and its Board of Trustees, directors, officers, employees and agents from any and all claims which may arise from said medical treatment. My signature certifies that I have read, understand, and agree to all statements and voluntarily consent to its contents. I consent to medical examination and treatment for myself/my child. I consent to urgent care/crisis counseling and consultation services for me/my child.

This consent will remain valid from the date of signature until you are no longer enrolled at Roberts Wesleyan University.

______________________________ Student Name (print)	_____ / _____ / _____ Birthdate
______________________________ Student Signature	_____ / _____ / _____ Date
______________________________ Parent/Guardian Name (print)	
______________________________ Parent/Guardian Signature if less than 18 (relationship to student)	_____ / _____ / _____ Date