May 2011

Dear Incoming student:

Welcome to St. John's. We understand that this is a busy and exciting time for you. We would like to focus your attention on some health requirements. Please read the following carefully.

Prior to matriculation, all students are required to submit a completed health form, which includes:

1. A recent physical exam given by your primary care provider-in light of busy primary care offices/tight schedules it would behoove you to make an appointment with your primary care provider as soon as you receive the form. This will ensure that it will be completed by the due date.

2. Documentation of immunizations including two doses of MMR (Measles, Mumps, Rubella), meningitis vaccination (or 2nd dose if 1st dose longer than 5 years) and a tetanus booster within the past 10 years

This four-page health form, required only once, provides a summary of your health history to date. It is extremely helpful to the health center staff and emergency health care providers, should you need emergency care. In addition, please note the Emergency Medical Authorization required of all persons under the age of 18. A witness is required if only one parent signs; if both parents sign, a witness is not necessary.

Your health forms should be returned in the envelope that you received from the Admissions Office addressed to the Director of Student Health. Send the completed health form directly to the Student Health Center PO Box 2800 Annapolis, MD 21404 by **August 1st**. (***Please make a copy of the completed health form for your records and in the event of loss in transit.***) If you have any questions, please call the Harrison Health Center at 410-626-2553.

The office closes for summer break on May 13, 2011 and reopens on August 22, 2011. Telephone messages and e-mails are checked during the break. For any questions or clarifications please leave a detailed voice mail message including your name and phone number, and your call will be returned as soon as possible. You may also e-mail questions to Nancy.Calabrese@sjca.edu or Lynda.Turner@sjca.edu. If you prefer to fax a note, the fax number is 410-626-2889.

We will be happy to discuss any health-related issues with your and or your parents. Please be assured that by law patient confidentiality is always protected under the federal HIPAA regulations.

Insurance and Prescriptions

Students should have the documentation they need to access health insurance. If a student will be covered under the insurance offered through the school, we will provide an insurance card and a prescription card. **If a student will be covered under a parent's policy, the student must have a card or copy stating the policy information. Please make a copy of the front and back of the insurance card and send it with the other health documents requested**. The student covered by a parent's policy needs to know how he or she will pay for prescriptions.

Immunization/Vaccinations

Effective June 1, 2000, the Maryland legislature passed a law requiring that college students living in dormitories either be vaccinated against meningitis or waive vaccination, in writing (a waiver form is available for optional download). You should be aware that outbreaks of

meningitis on college campuses have risen in recent years, though, St. John's College has not had any incidence of meningitis. Meningitis is a serious and potentially fatal disease that affects the brain and the spinal cord and can lead to permanent disabilities, such as hearing loss and brain damage.

You are strongly advised to receive your immunization for meningitis before arriving at St. John's. In the event that you are absolutely unable to meet this requirement, you will receive the meningitis vaccine at registration. **New CDC guidelines advise a 2nd dose if the 1st dose was administered 5 years ago or longer, and the cost is $106. If planning to receive the meningitis immunization at registration, please complete the enclosed form and pre-pay by check. You will be asked to remain in the Health Center for 15 minutes following the vaccination.**

Hepatitis B, likewise, can be debilitating and even fatal. Therefore, vaccination against hepatitis B is recommended by college health and public health experts for college students. Immunization against hepatitis B involves three injections over a six-month period, and cost to administer the hepatitis B series at the Health center is approximately $75 per dose. We recommend that you discuss both the meningitis immunization requirement and the facts about hepatitis with your primary care provider.

The Health Center also oversees prescribing and administration of other recommended immunizations, i.e. Gardasil for women (HPV vaccine) which involves three injections over a six-month period, at the cost of $135 per dose.

The other immunizations required for matriculation at St. John's College are Tetanus, and two doses of measles, mumps and rubella (MMR) vaccine. These are the standard immunizations required by all schools, nation-wide. St. John's College requires that students supply documentation of having received these immunizations, including the date immunized, prior to matriculation. ***If the required immunizations are not complete by registration, you will be asked to sign a form pledging to comply within 2 weeks. If you do not provide documentation of all required vaccinations within that time, you may be asked to withdraw from the college.***

Sincerely yours,

Nancy Calabrese, CRNP

Lynda Turner, CRNP

S. David Krimins, M.D.

MEDICAL AUTHORIZATION AND HEALTH HISTORY FORM
HARRISON HEALTH CENTER
ST. JOHN'S COLLEGE
P.O. Box 2800
Annapolis, Maryland 21404

To the Student:
YOU HAVE BEEN ACCEPTED TO ST.JOHN'S COLLEGE. Information you provide will not be used to influence your situation at the College. Information provided on this form is confidential and will not be released to anyone without the student's written consent. Please sign the Emergency Medical Authorization and General Consent, which are necessary to enable us to provide your health care, or, if you are under 18, please have your parents sign. PLEASE RETURN THIS FORM DIRECTLY TO THE HEALTH CENTER STAFF IN THE HARRISON HEALTH CENTER IN THE ENVELOPE PROVIDED.

Emergency Medical Authorization
In case of emergency, if I (we) cannot be reached, I (we) give my (our) consent for the Dean, Assistant Dean, College Nurse, or College Physician of St. John's College, Annapolis, Maryland, and Santa Fe, New Mexico, to authorize the health care provider in charge of the case, and the hospital to which the case of

____
Name of Student

is taken to administer any treatment, including blood transfusions, and to administer such anesthetics, and to perform such operations as may be deemed medically necessary in the diagnosis and treatment of the above named person.

______________________ ______________________________
Student's date of birth Student signature if age 18 or over

______________________ ____________________________ __________
Witness Parent or Guardian if student under 18 Date

Consent to communication of medical information

I authorize the Health Center clinicians to communicate information about my condition to my insurance company as necessary to obtain reimbursement for my expenses, to specialists as necessary to diagnose and treat my medical conditions, to diagnostic laboratories as needed to perform testing and to other Health Center clinicians as necessary to care for me and to monitor and improve the quality of care.

____ ________
Student signature if age 18 or over/Parent if student is under 18 years Date

Contact information
In case of emergency, notify (parent, guardian or spouse):
Name___________________________________ Relationship______________
Home address __________________________City, State_____________________ Zip code_______
Home phone ( )_________________ Business phone ( )________________Cell phone( )_____________

Student's primary care provider:
Name ______________________________ Address:_______________________ Phone: ( )___________

Student's health insurance:
Company: __________________________ Address:________________________ Phone: ( )____________
Is the primary care provider's authorization required for all diagnostic testing and/or referral to specialists?
__ yes __ no

STUDENT'S CELL PHONE # IF APPLICABLE________________________________

Family History

	Age	Health status	Occupation	If deceased, age and cause of death
Father				
Mother				
Sisters				
Brothers				

State relationship of blood relative--**parents, grandparents, and siblings**--who have had:

Alcoholism	Epilepsy	Psychiatric illness
Bleeding disorder	Heart disease	Stroke
Cancer	High blood pressure	Tuberculosis
Diabetes	Infectious disease	Other hereditary disease

Inactive medical problems

Give the approximate age at which you had any of the following:

Allergies, seasonal	Head injury	Migraine
Anorexia nervosa	Hearing loss	Mononucleosis
Asthma	Heart disease	Obsessive-compulsive disorder
Attention deficit disorder	Heart murmur	Rheumatic fever
Bipolar disorder	Hepatitis	Schizophrenia
Bleeding disorder	Herpes	Seizures
Bulimia	Joint injury	Suicide attempt
Chicken pox	Kidney disease	Thyroid disease
Depression	Liver disease	Tuberculosis
Diabetes	Malaria	Ulcer
Fainting	Meningitis	Other medical illness

Hospitalizations for injury, illness, surgery or diagnostic testing:

1. ____________________________________ Age______ 2. _______________________________ Age______

Current Problems: Please rank by circling the severity: 0 is for absent, 1,2,3 for increasing severity/frequency

Acne 0 1 2 3	Domestic violence 0 1 2 3	Sexual abuse 0 1 2 3
Alcohol abuse 0 1 2 3	Fainting 0 1 2 3	Suicidal thoughts 0 1 2 3
Allergies 0 1 2 3	Food restrictions, self-imposed 0 1 2 3	Other:
Anxiety 0 1 2 3	Headaches 0 1 2 3	
Attention deficit 0 1 2 3	Indigestion 0 1 2 3	
Depression 0 1 2 3	Insomnia 0 1 2 3	
Discord with parents 0 1 2 3	Menstrual problems 0 1 2 3	

Medication information:

Prescription medications: _______________ ________________ ________________

Over the counter medications: _______________ ________________ _______________

Allergies to medications:

Allergic to _________________ (name of medication)Reaction this medication elicits: _________________

Health Risks:
The following section asks about risky behaviors that college-age individuals sometimes adopt. The top health risks for college students are:

1. Accidents, often related to alcohol consumption
2. Upper respiratory illness, often related to smoking
3. Infectious diseases, often related to sexuality
4. Unwanted pregnancy

Please answer the following questions, and come to the Health Center after classes have begun to discuss your health risks. If you do not wish to be candid on this form, please come to the Health Center after classes have begun to discuss these matters in person.

Smoking:
Non-smokers are safest.
Do you smoke? __ yes __ no If yes, how many packs per day? _____________

Alcohol and other mind-altering substances:
Abstinence is safest.
Do you drink alcohol? __ no __ less than one drink/week __1-4 drinks/week __ more than 1 drink/day
Do you use street drugs? __yes __ no If yes, what drug?_________ How often?______

Automobile safety:
The safest practice is to always use seatbelts, never to drive after drinking alcohol, and to decline to ride with an individual who has been drinking alcohol.
Do you use seatbelts while riding in automobiles? __yes __ no
Do you drive after drinking alcohol? __ yes __ no Do you ride with people who have been drinking? __ yes __ no

Interpersonal conflicts:
It is safest to remove oneself from proximity with individuals who are physically violent, and to seek counseling if you have trouble curbing violent impulses.
Have you been physically violent with yourself or others? __ yes __ no

Sexuality:
Abstinence is safest.
If sexually active:
Are you having safe sex? __yes __ no Are you using contraception? __yes __no

Health maintenance
If you need information or counseling on any of these subjects, please ask your Primary Care Provider or come to the health center after school begins.

All students:
Have you been to the dentist in the past year? __yes __ no
Are your immunizations up to date and adequate for your lifestyle? __yes __ no
Recommended immunizations completed by age 18:
Tetanus booster every 10 years
Measles/mumps/rubella, 2 doses
Hepatitis B, 3 doses, usually initiated at age 11
Meningitis, 1 dose or 2 if > 5 years since 1st dose

Are you exercising for ½ hour at least 3 times a week? __ yes __ no
Are you eating at least 5 servings of fruits or vegetables a day? __ yes __no
Do you have a source of calcium in your daily diet? __ yes __ no
Do you have a method of dealing with stress? __yes __no What is the method?__________

Female students:
Have you had a Pap smear in the past year? __yes __ no Was it normal? __yes __ no
Do you know how to do a breast self-exam? __yes __no Do you do it monthly? __yes __ no

Male students:
Do you know how to do a testicular self-exam? __ yes __no Do you do it monthly? __yes __no

To be completed by Student's Primary Care Provider:

Student's Name______________________________ **Date of Birth**________________________

IMMUNIZATION RECORD

Required: to be completed and signed by your health care provider or attach copies of records

Tetanus booster within 10 years. Date ___/___/___(check__Td or __Tdap)
Measles vaccine (MMR). Two does **required.**
Dose 1 given at age 12-15 months or later. Date ____/____/____
Dose 2 given at age 4-6 years or later. Date ____/____/____
Meningitis (MCV4) required Date ____/____/____
If meningitis vaccine administered > 5 years-booster dose required
Date____/____/____
Hepatitis B (recommended 3 doses). Dates ___/___/___, ___/___/___, __/__/__
Polio (optional). Date ____/____/___

ALLERGIES TO MEDICATIONS: ____

Physical examination:

BP_______ Pulse_____ Height______ Weight_____

Corrected vision: Right 20/___ Left 20/___

Normal	System examined:	Abnormalities:
	Head, ears, nose, throat	
	Eyes	
	Cardiovascular	
	Pulmonary	
	Gastrointestinal	
	Genitourinary	
	Musculoskeletal	
	Skin	
	Neurologic	

PRIMARY CARE PROVIDER'S SIGNATURE_________________________________DATE___________
Print name: ____________________________

Address____________________________

City, State ________________ Zip Code_____

Telephone number ( ) _____________________
Fax number_______________________________
Email address______________________________

Harrison Health Center
St. John's College
PO Box 2800
Annapolis, MD 21404

MENINGOCOCCAL VACCINE PRE-PAYMENT FORM

Pre-ordering and Pre-paying for the meningococcal vaccine guarantees you a reserved dose August 24, 2011 from 8:30 a.m. to 12 noon at the time of registration.

Please print-

____

Student Name- Last Name First Name

____

Date of Birth SS#

Pre-Order/Pre-Pay Meningococcal vaccine: $106

Enclosed is my pre-payment check to St. John's College:

- ❑ Amount _______________

I understand that Pre-ordering and Pre-paying for the meningococcal vaccine will only guarantee me a reserved dose at the time of registration. In the event that I cannot arrange to attend at the scheduled time, I will be asked to sign a statement pledging completion of immunization within 2 weeks of registration. I may be asked to withdraw from the college if I do not comply.

<u>Please note: you will be asked to remain at the Health Center for 15 minutes after receiving the injection in order to observe for any adverse reaction.</u>

Student Signature ____Date: _________

Parent/Guardian (if under age 18) ___________________________Date: _________

Please return this form, payment, and completed Health Form to:

Harrison Health Center
St. John's College
PO Box 2800
Annapolis, MD 21404

Dear Students and Parents,

In order to provide you with the most comprehensive health care possible, we at the Counseling Center, ask you to consider the following suggestions.

1. If you have a learning disability that has been diagnosed for accommodation in high school and for which you take medication, we ask that you contact the Counseling Center before you arrive. We can be reached at bernadette.zorio@sjca.edu or 410-626-2552. Prescriptions must be monitored by a physician. The Counseling Center can provide a list of local psychiatrists to assist you, or you may choose to continue working with your current health-care provider. Documentation of learning accommodation plans should be forwarded to the office of the Assistant Dean.

2. Students who have other pre-existing conditions requiring psychotropic medication must contact the Counseling Center to ensure proper support and follow-up. Counselors provide referral and supportive counseling services for students on a regular basis.

We look forward to welcoming you to successful college experience.

Sincerely,

Judy T. Lazarus, ACSW LCSW-C
Bernadette Zorio, MSN, APRN, BC, CHTP
Jerry Januszewski, L.C.A.D.C.