

November 2009

Dear Incoming Student:

Welcome to Barnard College! This letter is intended as a guide to help you through the Health Service portion of the admissions process. We will also offer some important tips on how to take good care of yourself while you are here.

First, it is essential that you complete all of the medical forms that are included in the admissions packet. New York State law requires that all students have documentation of 2 measles, mumps and rubella vaccinations and that all students complete the Meningitis Response form.

**These forms are essential to your being allowed to register at Barnard.**

Please arrange an appointment with your medical provider in order to have all the proper forms completed in time. All forms must be sent together, at the same time, via fax or by mail. It is not necessary to send them both ways.

**All forms must be submitted together at the same time to avoid confusion about missing or duplicate pages**

**Forms should be submitted via fax to 212-854-2702 (preferred method)**

**OR** via mail to Barnard College Primary Care Health Service, Lower Level Brooks Hall  
3009 Broadway, New York, NY 10027

**These forms must be submitted by December 31, 2009**

**Please retain a copy of all forms for your records**

**Late submission of forms after the deadline may put you at risk for housing and registration holds**

Secondly, we have some suggestions for you on how to prepare for Barnard. Some of these suggestions are based on experience with current students, and some are based on recommendations endorsed by the Society for Adolescent Medicine. At the time of your required pre-college exam by your medical provider, please take advantage of that visit to get to know details about your health.

- Learn your family medical history. This may be in your records from when you were much younger and may contain information of which you are not aware.
- Obtain a copy of your immunization history for your own personal records.
- Discuss any ongoing medical or psychiatric problems with your medical provider and formulate a plan for the care you will need at Barnard. If you have a chronic illness, it would be advisable for you to bring a copy of your medical records with you. If ongoing medical follow-up is needed, please visit us at the Health Service when you arrive. We can either work with you here or refer you to a specialist as needed. (We maintain a list of board-certified specialists.)
- Learn about your health insurance coverage and if you have private family health insurance bring your insurance card with you.
  - Does your plan cover health care in New York City?
  - Do you have a prescription plan? What is your co-pay?

If you have a specific insurance question call your insurance company.

- There is no per-visit fee for you to be cared for in the Barnard Health Center. However, if you need a referral to an outside specialist, that visit is **not** free. In that case, if you have private family insurance, you will use your own insurance first, and then the mandatory insurance provided by Barnard College, will cover at least part of the referral visit. **The insurance will cover visits only if a Barnard Health Service provider has referred you.**
- We maintain a small dispensary on site for commonly used medications, for which there is a charge. We accept Visa, MasterCard, or Checks (from a U.S. bank). Please note that we **do not** accept Cash, American Express or Discover.  
If you have private insurance with a prescription plan, you might be given a prescription to be filled in a local pharmacy, as your co-pay may be less than we charge you for your medication.
- Bring a small medical kit to use “*just in case.*” This should include the following:
  - a digital thermometer
  - acetaminophen or ibuprofen
  - diphenhydramine (Benadryl)
  - your favorite cold preparation
  - a chemical ice pack
  - Band-aids
  - antibiotic ointment
  - and anything else that you wish to include

We look forward to meeting you. Please let us know if there is anything we can do to help make your transition here an easier one.

Sincerely,

*Brenda Slade*  
Brenda Slade, NP, MA  
Director

*Marjorie Seidenfeld*  
Marjorie Seidenfeld, MD  
Medical Director

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**The deadline to submit these forms is December 31, 2009**

*This form must be completed by your Doctor, not by your parent*

*Please Print Legibly in Black Ink*

Student's Full Name (First, Middle, Last) \_\_\_\_\_ Last 4 digits of Social Security # \_\_\_\_\_

Date of Birth: (MM/DD/YY) \_\_\_\_\_

Date of Exam (must be within the last 6 months): \_\_\_\_\_

### **2 ITEMS REQUIRED BY NEW YORK STATE LAW** **FOR YOU TO REMAIN ON CAMPUS: (A and B)**

#### **A. Documentation of Measles, Mumps and Rubella Vaccination**

Note to Physician: If patient has not received 2 measles, 2 mumps, and 1 rubella vaccination all after 1 year of age, please give her an MMR immunization during her visit. **No student will be permitted to register without complete immunization records.** This is a requirement under New York State Law, and we cannot allow any exceptions.

Measles vaccine \_\_\_\_\_ Mumps: \_\_\_\_\_ Rubella \_\_\_\_\_  
(MM/DD/YYYY) (MM/DD/YYYY) (MM/DD/YYYY)

MMR #1 \_\_\_\_\_ MMR #2 \_\_\_\_\_  
(MM/DD/YYYY) (MM/DD/YYYY)

Immune by Titer: Result \_\_\_\_\_ titer Date: \_\_\_\_\_  
(Negative or Positive) (MM/DD/YYYY)

#### **B. Completion of Meningitis Response Form** **See page 3**

### **REQUIRED BY BARNARD COLLEGE PRIMARY CARE HEALTH SERVICE:**

#### **Screening for Risk of Tuberculosis: Please answer Yes or No**

Have you ever lived for at least 1 month in the Middle East, Africa, Asia, or Latin America? \_\_\_\_\_

Have you ever had close contact with anyone with tuberculosis? \_\_\_\_\_

Have you ever had close contact with anyone who is incarcerated, homeless, a migrant farm worker, HIV infected or an IV drug user? \_\_\_\_\_

#### **If you answered Yes to any of the above questions, a PPD or Mantoux test is required.**

Date of PPD placement: \_\_\_\_\_ Date of PPD Reading \_\_\_\_\_

Result of PPD: \_\_\_\_\_ negative \_\_\_\_\_ positive: \_\_\_\_\_ mm reaction

If positive:

Date of Chest X-ray: \_\_\_\_\_ Results of Chest X-ray: \_\_\_\_\_

TB prophylaxis given: \_\_\_\_\_

# BARNARD

## Primary Care Health Service

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Student's Full Name (First, Middle, Last) \_\_\_\_\_ Last 4 digits of Social Security # \_\_\_\_\_

Date of Birth: (MM/DD/YY) \_\_\_\_\_ Date of Exam (must be within the last 6 months): \_\_\_\_\_

### Record of Immunizations:

Tetanus, Diphtheria, Pertussis: \_\_\_ Completed basic series Last booster date: \_\_\_\_\_ Tdap (date given): \_\_\_\_\_

Polio (IPV or OPV): \_\_\_ Completed basic series Last booster date: \_\_\_\_\_

Hepatitis A: Dose #1 (date) \_\_\_\_\_ Dose #2 (date) \_\_\_\_\_ **OR** Titer result \_\_\_\_\_ Date \_\_\_\_\_

Hepatitis B: Dose #1 (date) \_\_\_\_\_ Dose #2 (date) \_\_\_\_\_ Dose #3 (date) \_\_\_\_\_ **OR** Titer result \_\_\_\_\_ Date \_\_\_\_\_

Varicella (Chicken Pox): Dose #1 (date) \_\_\_\_\_ Dose #2 (date) \_\_\_\_\_ **OR** Titer result \_\_\_\_\_ Date \_\_\_\_\_

Gardasil (HPV) Vaccine: Dose #1 (date) \_\_\_\_\_ Dose #2 (date) \_\_\_\_\_ Dose #3 (date) \_\_\_\_\_

Other Immunizations: \_\_\_\_\_

### Allergies:

\_\_\_ No known drug allergies

\_\_\_ Allergic to the following medications: (please indicate reaction): \_\_\_\_\_

**Please list all significant medical problems:** \_\_\_\_\_

**Please list all surgeries:** \_\_\_\_\_

**Please list all medications the student is currently taking:** \_\_\_\_\_

**Physical Examination:** Height: \_\_\_\_\_ (in.) Weight: \_\_\_\_\_ (lbs) BP: \_\_\_\_\_ P: \_\_\_\_\_

**Please list any significant abnormal medical findings:**

**Provider's Signature:** \_\_\_\_\_ **Date of exam:** \_\_\_\_\_

**Provider's Printed Name:** \_\_\_\_\_

**Office Address:** \_\_\_\_\_

**Provider telephone:** \_\_\_\_\_ **Provider Fax:** \_\_\_\_\_

**Please place Provider's Stamp in the box:**



### Barnard Health Service Information and Consent Form

**Welcome to Barnard Health Service!** We are looking forward to working with you during your time at Barnard. Our clinical services offer a full range of primary care and women's health care with referral to outside consultants when indicated. **There is no charge for your visit. Most laboratory tests are without charge, as are x-rays, and other procedures we may order. A wide variety of medications are offered onsite at a significant discount.**

In addition to clinical care, we offer a variety of other services: nutrition counseling, stress reduction programs and sexual health counseling. We work closely with other health-related services, including the Furman Counseling Center, the Well-Woman Health Promotion Program, the Alcohol Substance Awareness Program (ASAP), and the Barnard-Columbia Rape Crisis Anti-Violence Support Center. More information on staff, services, hours and links to other health sites is available at [www.barnard.edu/health](http://www.barnard.edu/health).

**In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), strict confidentiality is maintained for all health-related information and medical records within the Health Service. No information will be released outside the Health Service, either within the college or to your family, without your express prior consent.** We operate as a clinic and therefore your clinician may consult with another clinician *within* the Health Service, ASAP or the Counseling Center if it is clinically necessary to provide you with the most appropriate care.

Our mission is not only to provide you with excellent and sensitive clinical care but also to enable you to become informed and knowledgeable health care consumers. We ask that you help us by providing feedback regarding your satisfaction with our services. Specifically, if you are dissatisfied with your care at any point, *please* either speak with the clinician involved, or with Brenda Slade N.P., M.A., Director of the Service (212-854-2091 or [bslade@barnard.edu](mailto:bslade@barnard.edu)).

**PLEASE SEE THE BARNARD STUDENT HEALTH SERVICE NOTICE OF PRIVACY PRACTICES AS REQUIRED BY FEDERAL LAW, WHICH DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN HAVE ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION**

#### **Receipt of Notice of Practice Information and Privacy Practices Written Acknowledgement**

**I have been made aware of and offered the opportunity to read a copy of Barnard College Primary Care Health Service's Notice of Practice Information and Privacy Practices.**

*Please print legibly in black ink*

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Patient Name

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### Parent/Legal Guardian Section of Health Form

#### Consent for Treatment of Minors:

**If your daughter is UNDER age 18 this form must be completed.  
(Please print legibly in black ink.)**

I, \_\_\_\_\_ hereby give permission to the clinicians at  
(Name of Parent/Guardian)  
Barnard College Health Services to provide medical care for \_\_\_\_\_.

I understand that clinicians are compelled by the laws of the State of New York to maintain my daughter's confidentiality with regard to all sexuality-related health needs.

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Signature of Parent/Legal Guardian

Date

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