



Welcome to Macalester! To protect your personal health and the health of the Macalester community, we have several forms for you to complete.

These forms are REQUIRED of all students – the only exception is the Athletic Department Insurance Verification form that is required for *all intercollegiate athletes only*. Failure to complete and return these forms will jeopardize your status as a student at Macalester and may result in validation issues and/or delays in your ability to participate in sports activities.

What do we do with these forms? A file is created for every new student and is kept by the Health & Wellness Center (HWC). We will then have your basic health information when you use our services. The state of Minnesota requires that all post-secondary students be up-to-date in their immunizations and that the college have a record of those immunizations. Your information also lets us address public health concerns. For example: if chicken pox shows up on campus, we know which students might be at risk because they haven't had chicken pox or the vaccination.

The Health & Wellness Center (HWC) will review forms for initial medical athletic eligibility for *all* students and will communicate to the Athletics Department if a student is eligible with a simple "yes" or "no". If you are on a team roster (intercollegiate or club) but are not approved as medically eligible, you will not be allowed to practice or compete until medically cleared by the HWC and you will need to work with the HWC to address concerns holding up your participation. The most common reasons students are not approved include incomplete information, missing physician signatures, etc. So review ALL forms for completeness!

Intercollegiate and club sports athletes (present and future). For intercollegiate student athletes, these forms will be shared with the Athletics Department's athletic trainers and physicians. These professionals need the information to monitor and support your health during your sport season. There is a signature box on the health history and examination form releasing this information to the Athletic Medicine staff. This is confidential information and will not be shared outside of the departments without your written consent. If you are ever treated for anything (medical or counseling) in the HWC, we will not release it to Athletic Medicine without your written consent.

Speaking of confidential information... All health information is considered confidential. Your records will never be shared without your written consent. Sorry, parents – this includes you, too, if your student is 18+. Students, we will work with you to manage your health so that you can fully participate in the Macalester experience, both in and out of the classroom. Parents and students should establish basic mutual expectations regarding communication on health issues *before* coming to Macalester so that concerns do not develop later on.

DEADLINES: July 15, 2010 for fall athletes; August 1, 2010 for all other students

FORMS SUMMARY

ALL STUDENTS

- Health History Record (Pages 3, 4, 5) Student – complete & sign (If under 18, parent signs as well)
- Physical Exam (Pages 7, 8) Health Care Provider – complete & sign
- Immunization Record (Page 11) Student or Parent– complete
- TB Screening/TB Risk Assessment/TST results (Pages 13, 14) Student – Complete page 13; if you answered YES to any of the questions on Page 13, Page 14 must be completed by Health Care Provider.
- Notice of Privacy Practices (Pages 15 & 16) Student - sign

SEND TO: Health & Wellness Center, Macalester College, 1600 Grand Avenue, St. Paul, MN 55105 or FAX to: 651.696.6687

INTERCOLLEGIATE ATHLETES ONLY

- Intercollegiate Athletics Insurance Requirements (Page 9) Parent – Sign and attach copy of insurance card (front and back). **DO NOT FAX** – original document is required.

SEND TO: Paula Natvig, Athletic Medicine, Macalester College, 1600 Grand Avenue, St. Paul, MN 55105

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MACALESTER COLLEGE
Health & Wellness Center/Athletics Department

1600 Grand Avenue, Saint Paul, Minnesota 55105
 Phone : 651.696.6275 – FAX : 651.696.6687
 Email : health@macalester.edu

**Form must be completed
 and returned by mail, fax
 or e-mail before August 1st;
 July 15 for athletes**

Return completed forms to: 1600 Grand Ave., St. Paul, MN 55105
 FAX : 651.696.6687

HEALTH HISTORY RECORD – DOMESTIC STUDENT

I. STUDENT'S REPORT OF MEDICAL HISTORY... (PLEASE PRINT)

Last Name	First Name	Middle	Gender	Date of Birth
Home Address (Number and Street)	City or Town	State	Country	Zip
Next of Kin: Name	Relationship	Primary Phone Number	Secondary Phone Number	
Name of person to call in case of emergency :	Relationship	Primary Phone Number	Secondary Phone Number	
Student's Email Address	Student's Cell Phone Number			
Primary Health Care Provider (print name)	Primary Health Care Provider Office Phone Number			

Family History	Current Age/Occupation	Health Status:
Father		
Mother		
Siblings		
Are you adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No With whom do you live? <input type="checkbox"/> Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Spouse <input type="checkbox"/> Self <input type="checkbox"/> Other		

PLEASE CIRCLE YES IF YOU HAVE HAD ANY OF THE FOLLOWING DISEASES OR CONDITIONS.

GENERAL	
Has a doctor ever denied or restricted your participation in sports for any reason or told you to give up sports?	Yes/No
Do you have ongoing medical conditions (i.e. diabetes, asthma)?	Yes/No
Have you ever spent the night in a hospital?	Yes/No
Have you ever had surgery?	Yes/No
Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	Yes/No
Have you ever been told you have protein/sugar in your urine?	Yes/No
When exercising in the heat, do you have severe muscle cramps or become ill?	Yes/No
Do you have any concerns that you would like to discuss with a doctor?	Yes/No
	Yes/No
ALLERGIES	
Do you have allergies to any medications?	Yes/No
If yes, please list	
Other allergies:	Yes/No
If yes, please list	
CARDIOVASCULAR	
Have you ever passed out or nearly passed out DURING exercise?	Yes/No
Have you ever passed out or nearly passed out AFTER exercise?	Yes/No
Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	Yes/No
Does your heart race or skip beats during exercise?	Yes/No
Has a doctor ever told you that you have? (circle all that apply) High Blood Pressure High Cholesterol A Heart Infection Rheumatic Fever	
Has a doctor ever ordered a test for your heart? (i.e. ECG, echocardiogram, stress test)	Yes/No
Has anyone in your family died suddenly and unexpectedly for no apparent reason?	Yes/No
Does anyone in your family have a heart problem?	Yes/No
Has any family member or relative died of heart problems or of sudden death before age 50?	Yes/No
Has anyone in your family less than 50 years old had unexplained drowning while swimming or an unexplained car accident?	Yes/No
Does anyone in your family have Marfan syndrome?	Yes/No

ORTHO	
Have you ever had an injury, like a sprain, muscle or ligament tear or tendonitis that caused you to miss a practice or a game?	Yes/No
Have you had any broken or fractured bones, or dislocated joints?	Yes/No
Have you had a bone/joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast or crutches?	Yes/No
If yes, circle below: Head Neck Shoulder Chest Upper Arm Elbow Forearm Hand/Fingers Upper Back Lower Back Hip Thigh Knee Calf/Shin Ankle Foot/Toes	
Have you ever had a stress fracture?	Yes/No
Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	Yes/No
Do you regularly use a brace or assistive device?	Yes/No
RESPIRATORY	
Has a doctor every told you that you have asthma or allergies?	Yes/No
Do you cough, wheeze, chest tightness, or have difficulty breathing during or after exercise?	Yes/No
Is there anyone in your family who has asthma?	Yes/No
Have you ever used an inhaler or taken asthma medicine?	Yes/No
Do you develop a rash or hives when you exercise?	Yes/No
Do you get tired more quickly than your friends do during exercise?	Yes/No
INFECTIOUS	
Have you had infectious mononucleosis (mono) within the last month?	Yes/No
Have you had chicken pox?	Yes/No
Have you had German measles?	Yes/No
Have you had measles?	Yes/No
Have you had mumps?	Yes/No
SKIN	
Do you have any rashes, pressure sores, or other skin problems?	Yes/No
Have you had a herpes skin infection?	Yes/No
NEUROLOGIC	
Have you ever had a head injury or concussion?	Yes/No
Have you been hit in the head and been confused or lost your memory?	Yes/No
Have you ever had a seizure?	Yes/No
Do you have headaches with exercise?	Yes/No
Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	Yes/No
Have you ever been unable to move your arms or legs after being hit or falling?	Yes/No
BLOOD	
Are you anemic?	Yes/No
Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	Yes/No
VISION	
Have you had any problems with your eyes or vision?	Yes/No
Do you wear glasses or contact lenses?	Yes/No
Do you wear protective eyewear, such as goggles or a face shield?	Yes/No
NUTRITION	
Are you happy with your weight?	Yes/No
Are you trying to gain or lose weight?	Yes/No
Has anyone recommended you change your weight or eating habits?	Yes/No
Do you limit or carefully control what you eat?	Yes/No
FEMALES ONLY	
Have you ever had a menstrual period?	Yes/No
How old were you when you had your first menstrual period?	
How many menstrual periods have you had in the last year?	

PERSONAL HISTORY

PLEASE ELABORATE ON ANY POSITIVE ANSWERS WITH ADDITIONAL COMMENTS IN THE SPACE PROVIDED BELOW.
(ALL ANSWERS ARE CONFIDENTIAL)

- A. List any illness, injury, surgery, or hospitalization (gives dates and explain).
- B. Do you take medication routinely? Reason and Type: Yes No
- C. Do you have any dietary restrictions or food allergies? Yes No
- D. Have you ever been diagnosed and/or treated for ADD/ADHD Yes No
Do you currently take medication to help manage your ADD/ADHD? If yes, what do you take?
- E. Have you ever been diagnosed or treated for a mental health condition Yes No
If yes, for which of the following conditions have you been diagnosed or treated? (please check all that apply)
- | | |
|--|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Bipolar Disorder |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Anorexia or bulimia |
| <input type="checkbox"/> Substance abuse or dependency | <input type="checkbox"/> Other (please list: _____) |
- F. Do you currently take medication to help manage a mental health condition? Yes No
If yes, what do you take?
- G. Have you ever been hospitalized for a mental health condition? Yes No

Please read and sign below before participation in any athletic activity.

In order for you to participate in intercollegiate, intramural and club sports while you attend Macalester, the Health & Wellness Center must indicate to the Athletic Medicine Department personnel that you are approved to participate in these activities; and share with them a copy of your current health history record, physical and immunization records.

I authorize the Health & Wellness Center to indicate to the Athletic Medicine Department whether or not I am approved by my health care provider to participate in sports activities and to release a copy of my current health history record, physical examination and immunization records. This may be shared with my consent.

Student's Signature

Birthdate

Date

If you are under 18 please have your parent/guardian sign below. Students under 18 years of age must have parental permission to receive medical treatment or emergency care through our Health & Wellness Center. I give permission for my son/daughter to receive medical treatment or emergency care through the Health & Wellness Center.

Parent/Guardian Signature

Date

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**Macalester College
MEDICAL EXAMINATION**

TO BE COMPLETED BY THE EXAMINING HEALTH CARE PROVIDER (i.e. MD, DO, NP, PA)

RETURN TO: Macalester College Health & Wellness Center, 1600 Grand Ave., St. Paul, MN 55105

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Student's Name

Date of Birth

Age

Gender

MEDICAL EXAMINATION – MUST BE COMPLETED WITHIN 6 MONTHS OF COMING TO MACALESTER

Height: _____ Weight: _____ BMI (optional) _____ Arm Span _____ (optional screen for Marfan Syndrome)

Pulse: _____ BP: _____ / _____ Hearing Screen: Right _____ Left _____ (Audiogram or confrontation)

Vision: R - 20/ _____ L 20/ _____ Corrected: Yes/No Contacts Yes/No Pupils: Equal _____ Unequal _____

LAB (if necessary) Results: _____

EXAM	NORMAL	ABNORMAL (explain)
Appearance	Y/N	
HEENT	Y/N	
Eyes	Y/N	
Fundoscopic	Y/N	
Pupils	Equal/Unequal	
Ears/Nose	Y/N	
Hearing	Y/N	
Throat	Y/N	
Dental	Y/N	
Lymph Nodes	Y/N	
Thyroid	Y/N	
Heart		
Murmurs	Y/N	
Pulses	Y/N	
Lungs	Y/N	
Abdomen	Y/N	
Genitourinary (male)	Y/N	
Hernia	Y/N	
Skin	Y/N	
Musculoskeletal		
Neck	Y/N	
Back	Y/N	
Shoulder/Arm	Y/N	
Elbow/Forearm	Y/N	
Wrist/Hand/Fingers	Y/N	
Hip/Thigh	Y/N	
Knee	Y/N	
Leg/Ankle	Y/N	
Foot/Toes	Y/N	
Duck Walk	Y/N	
Neurological	Y/N	
Psychological	Y/N	

Is patient under treatment of any kind at this time? Yes : No
 Explain:

Physical/Mental Disabilities or impairment? Yes : No
 Explain:

Macalester College
INTERCOLLEGIATE AND CLUB SPORT MEDICAL CLEARANCE FORM

RETURN TO: Macalester College Health & Wellness Center, 1600 Grand Ave., St. Paul, MN 55105

NOTE: Please have your health care provider complete this page even if you do not plan on participating in any intercollegiate or club activities at this time.

Student Name: _____ **Date of Birth:** _____ **Gender:** _____

Anticipated sport(s) participation (see list below): _____

Date of Examination: _____

I certify that the above student has been medically evaluated and is deemed to be physically fit to:
(Check one box)

_____ Participate in **ALL** Macalester Varsity or Club Sports

_____ **Not cleared** for these specific sport activities (list all that apply) EXPLAIN: _____

_____ **Not cleared** for **ANY** sports activities. EXPLAIN: _____

_____ Requires further evaluation before a final recommendation can be made. EXPLAIN: _____

I have examined the above named student and have completed the sports qualifying physical examination as requested.

Health Care Provider Signature: _____ Printed Name: _____

Clinic Address: _____

Office Phone: _____ Office Email: _____ Office FAX: _____

MACALESTER COLLEGE SPORT ACTIVITIES 2010-11

Intercollegiate Sports

Baseball
Basketball
Cross Country
Football
Golf
Soccer
Softball
Volleyball
Water Polo (women)

Swimming and/or Diving
Tennis
Track and Field

Club Sports

Crew
Ice Hockey
Lacrosse
Nordic Skiing
Rugby
Ultimate Frisbee
Water Polo (men)

MACALESTER COLLEGE INTERCOLLEGIATE ATHLETICS INSURANCE REQUIREMENTS

Return to: Paula Natvig, Athletic Trainer, 1600 Grand Ave., St. Paul, MN 55105

Macalester College requires all students to demonstrate evidence of health insurance every year. Students must go online to either opt out of the college Health Insurance policy by providing information on coverage or waive in to purchase the policy that the College offers. In addition, all Macalester College intercollegiate student-athletes must provide evidence of insurance that includes coverage for athletically-related injuries and coverage of up to \$90,000.00. This is a NCAA requirement and a prerequisite for practice and competition. No student will be allowed to participate in any way until such evidence of current insurance coverage is on file with the Macalester College Department of Athletics. The below Acknowledgement of Insurance Requirements form and an insurance card, or photocopy of both sides, must be on file before a student can participate. Insurance must provide coverage up to a minimum of at least \$90,000 and cover athletically-related injuries. ***Macalester College will assume no responsibility whatsoever for the payment of, or authorization to pay, medical expenses resulting from injuries that occur while participating in intercollegiate athletics at Macalester College.***

If you have questions regarding the terms of your coverage, you should contact your insurer immediately. Please be sure to note if there are any exclusions in your policy regarding athletically-related injuries.

The NCAA’s Catastrophic Injury Insurance Program covers student-athletes who are catastrophically injured while participating in a covered intercollegiate athletic activity (subject to all policy terms and conditions). The policy has a \$90,000 deductible. This coverage does not qualify as the basic coverage required for participation in athletics at Macalester College. It is **supplemental coverage** in the event of a catastrophic injury. More information on this program can be found on the NCAA’s web-site at www.ncaa.org. If you have any questions regarding this requirement, please contact Paula Natvig at 651-696-6162 or Natvig@macalester.edu.

Acknowledgement of Insurance Requirements

STUDENT ATHLETE	MACALESTER COLLEGE ID	DATE OF BIRTH	SPORT

I, _____ as parent, guardian, or legal representative attest that _____
 (Name, please print) (Student-Athlete Name, please print)
 has insurance coverage under a current insurance policy for injuries that occur while he/she is participating in intercollegiate athletics. This policy covers claims to at least **\$90,000**.

If there is a material change in coverage or expiration of coverage, I agree to notify Macalester College of this development and update the insurance information I have on file with Macalester College.

I understand and agree that Macalester College will assume no responsibility whatsoever for the payment of, or authorization to pay medical expenses resulting in injuries that occur while participating in intercollegiate athletics at Macalester College.

 (Parent Signature)

 (Date)

PLEASE ATTACH COPIES OF YOUR INSURANCE CARD BELOW

<p><u>FRONT of Insurance Card</u> (please secure all edges with glue or tape)</p>	<p><u>BACK of Insurance Card</u> (please secure all edges with glue or tape)</p>
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**Macalester College
IMMUNIZATION RECORDS**

Return To: Macalester College Health & Wellness Center, 1600 Grand Ave., St. Paul, MN 55105

**Macalester College and the State of Minnesota REQUIRE PROOF that you have had the following immunizations.
You will not be able to attend classes until the Health & Wellness Center has proof that you are in compliance with these requirements.
A copy of your immunization records may be attached in place of completing this form.**

STUDENT'S NAME _____ **BIRTHDATE** _____

(Dates must include month, day, and year. All information must be in English)

TETANUS-DIPHTHERIA (REQUIRED) (Td Booster within the last 10 years; to Tdap after age 18)

2. Tetanus-Diphtheria Booster (Td) within the last 10 years..... / /
And/Or: Mo Day Yr
 3. Tdap Booster (after age 18) / /
 Mo Day Yr

M.M.R. (MEASLES, MUMPS, RUBELLA) (REQUIRED)

- H. Dose 1 – immunized at 15 months of age or later..... / /
 Mo Day Yr
 2. Dose 2 – immunized at 5 years of age or later..... / /
 Mo Day Yr

The following immunizations are RECOMMENDED, but not required.

- D. VARICELLA (Chicken Pox)** Two doses of vaccine given at least one month apart if no history of having chicken pox.
 1. History of disease Yes No
 2. Varicella antibody test / / Reactive (+) Non Reactive (-)
 Mo Yr
 3. Varivax immunization Dose #1 / / Dose #2 (given at least one month after 1st dose) / /
 Mo Day Yr Mo Day Yr

- E. HEPATITIS B** Three doses of vaccine or positive surface antibody test
 1. Hepatitis B vaccination #1 / / #2 / / #3 / /
OR Mo Day Yr Mo Day Yr Mo Day Yr
 2. Hepatitis B Surface Antibody Result: Reactive (+) Non Reactive (-) Test Date: / /
 Mo Day Yr

- F. HEPATITIS A** Two Doses of vaccine
 1. Hepatitis A vaccination #1 / / #2 / /
 Mo Day Yr Mo Day Yr

- F. MENINGOCOCCAL VACCINE (Menomune or Menactra)** Recommended by American College Health Association
 for all students living in dorms under age 25..... Menactra Menomune..... Dose / /
 Mo Day Yr

- G. HPV Vaccine (Gardasil)** – Recommended for females and males < 26 years old for prevention of cervical cancer and genital warts.
 #1 / / #2 / / #3 / /
 Mo Day Yr Mo Day Yr Mo Day Yr

- H. POLIO** #1 / / #2 / / #3 / / #4 / /
 Mo Day Yr Mo Day Yr Mo Day Yr Mo Day Yr

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Macalester College
Tuberculosis (TB) Screening Testing
THIS FORM IS TO BE COMPLETED BY THE STUDENT

Return To: Macalester College Health & Wellness Center, 1600 Grand Ave., St. Paul, MN 55105

Name: _____ Date of Birth: _____

STEP 1: Please answer the following questions:

- Have you ever had a positive tuberculin skin test? Yes No
- Have you ever had close contact with anyone who was sick with tuberculosis? Yes No
- Have you ever been vaccinated with BCG? Yes No
- Were you born in one of the countries listed below and arrived in the United States within the past 5 years? Yes No (If YES, please X the country/ies)
- Have you ever traveled to/in one or more of the countries listed below? ** Yes No (If YES, please X the country/ies)

** The significance of the travel exposure should be discussed with a health care provider and evaluated.

X		X		X		X		X			
	Afghanistan		Cape Verde		Guam		Malawi		Palau		Sudan
	Algeria		Central Africa		Guatemala		Malaysia		Panama		Suriname
	Angola		Chad		Guinea		Maldives		Papua New Guinea		Syrian Arab Republic
	Anguilla		China		Guinea-Bissau		Mali		Paraguay		Swaziland
	Argentina		Columbia		Guyana		Marshall Islands		Peru		Tajikistan
	Armenia		Comoros		Haiti		Mauritania		Philippines		Tanzania-UR
	Azerbaijan		Congo		Honduras		Mauritius		Poland		Thailand
	Bahamas		Congo DR		India		Mexico		Portugal		Timor-Leste
	Bahrain		Cote d'Ivoire		Indonesia		Micronesia		Qatar		Togo
	Bangladesh		Croatia		Iran		Moldova-Rep.		Romania		Tokelau
	Belarus		Djibouti		Iraq		Mongolia		Russian Federation		Tonga
	Belize		Dominican Republic		Japan		Montenegro		Rwanda		Tunisia
	Benin		Ecuador		Kazakhstan		Morocco		St. Vincent & The Grenadines		Turkey
	Bhutan		Egypt		Kenya		Mozambique		Sao Tome & Principe		Turkmenistan
	Bolivia		El Salvador		Kiribati		Myanmar		Saudi Arabia		Tuvalu
			Equatorial Guinea		Korea-DPR		Namibia		Senegal		Uganda
	Bosnia & Herzegovina		Eritrea		Kuwait		Nauru		Seychelles		Ukraine
	Botswana		Estonia		Kyrgyzstan		Nepal		Sierra Leone		Uruguay
	Brazil		Ethiopia		Lao PDR		New Caledonia		Singapore		Uzbekistan
	Brunei Darussalam		Fiji		Latvia		Nicaragua		Solomon Islands		Vanuatu
	Bulgaria		French Polynesia		Lesotho		Niger		Somalia		Venezuela
	Burkina Faso		Gabon		Liberia		Nigeria		South Africa		Viet Nam
	Burundi		Gambia		Lithuania		Niue		Spain		Wallis & Futuna Island
	Cambodia		Georgia		Macedonia-TFYR		N. Mariana Islands		Sri Lanka		W. Bank & Gaza Strip
	Cameroon		Ghana		Madagascar		Pakistan		Sudan		Yemen
											Zambia
											Zimbabwe

STEP 2:
 If the answer is **YES** to any of the above questions, Macalester College requires that a **health care provider** complete a tuberculosis risk assessment (**to be completed within 3 months prior to the start of classes**). See Step 3

If the answer is to all of the above questions is NO, no further testing or further is required at this time. Again, if you answered YES to any of the above questions, move to Step 3

STEP 3: Required ONLY if student answered YES to any questions on Step 1 (previous page)

Persons with any of the following are candidates for mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented, proceed to next page

**Macalester College
Tuberculosis (TB) Risk Assessment
TO BE COMPLETED BY HEALTH CARE PROVIDER**

Return To: Macalester College Health & Wellness Center, 1600 Grand Ave., St. Paul, MN 55105

RISK FACTOR:

- Recent close contact with someone with infectious TB disease? Yes No
Foreign-born from (or travel to) one or more of the countries listed under Step 2? Yes No
Fibrotic changes on a prior chest x-ray suggesting inactive or past TB disease? Yes No
HIV/AIDS? Yes No
Immunosuppressed (equivalent of >15 mg/day of prednisone for > 1month or TNF- α antagonist)? Yes No
History of illicit drug use? Yes No
Resident, employee, or volunteer in a high-risk congregate setting? Yes No
Medical condition associated with increased risk of progressing to TB disease if infected Yes No

1. Does the student have signs or symptoms or active tuberculosis disease? Yes No

*If NO, proceed to 2 or 3.

*If YES, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

2. Tuberculin Skin Test (TST)

(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no indurations, write "0". The TST interpretation should be based on mm of indurations as well as risk factors).

Date TST given: _____ Date TST Read: _____ Result _____ mm of induration
Interpretation: Positive Negative

Health Care Provider Printed Name: _____ Health Care Provider Signature: _____
Office Phone Number: _____ Office FAX Number: _____

3. Interferon Gamma Release Assay (IGRA)

Date Obtained: _____ (specific method) QFT-G QFT-GIT other _____
Result: Negative Positive Intermediate

4. Chest x-ray (required if TST or IGRA is positive) Enclose Copy of Chest X-Ray Report

Date of chest x-ray: _____ Result: normal abnormal _____

Interpretation guidelines

>5mm is positive:

- *Recent close contacts of an individual with infectious TB
- *Persons with fibrotic changes on a prior chest x-ray consistent with past TB disease
- *Organ transplant recipients
- *Immunosuppressed person: taking >15 mg/d of prednisone for > 1 month; taking TNF- α antagonist
- *Persons with HIV/AIDS

>10 mm is positive:

- *Persons born in a high prevalence country or who resided in one for a significant* amount of time
- *History of illicit drug use
- *Mycobacteriology laboratory personnel
- *History of resident, worker or volunteer in high-risk, congregate settings
- *Persons with the following clinical conditions; silicosis, diabetes mellitus, chronic renal failure, leukemia's and lymphomas, head, neck or lung cancer, low body weight (>10% below ideal), gastrectomy or intestinal bypass, chronic malabsorption syndromes

>15 mm is positive:

- *Persons with no known risk factors for TB disease

**The significance of the exposure should be discussed with a health care provider and evaluated.*

MACALESTER COLLEGE HEALTH AND WELLNESS CENTER
Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed
Please review carefully

We recognize our responsibility for safeguarding the privacy of your health information. This notice describes your rights and our obligations for using your health information and informs you about laws that provide special protections for your health information. It also explains how your personal health information is used and how, under certain very special circumstances, it may be disclosed to those who need to access it. It tells you how any changes in this notice will be made available to you.

Understanding what is in your record and how your health information is used helps you to:

- Better understand who, what, where and why others may access your health information;
- Ensure accuracy in the record; and
- Decide how best to contact you (for example, by phone, e-mailing, or sending you a letter) to inform you about diagnostic results and to advise you about other health-related benefits and services.

Personal Health Information Use

Each time you visit the Health and Wellness Center, a record of your visit is made. This record contains documentation of your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often called your health or medical record, serves as a:

- Means of communication among the health professionals who contribute to your care;
- Legal record describing the care you received;
- Source of information for public health officials;
- Source of data for facility planning;
- Tool with which we can monitor, evaluate and continually work to improve the care we render and the outcomes we achieve; and
- Source of information that we may disclose to researchers when their research proposal has been approved by an Institutional Review Board and with established protocols to ensure the privacy of your health information.

Health and Wellness Center Responsibilities

We are required to:

- Maintain the privacy of your health information;
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction; and
- Accommodate reasonable request you may have, to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will advise you in advance. We will not use or disclose your health information without your authorization, except as described in the notice.

Use and Disclosure Without Your Authorization

The law allows or requires us to use and disclose your health information without your authorization for a number of purposes designed to enhance health care services, protect patient safety, public health, and to ensure that our facilities and practitioner comply with government and accreditation standards. For example, we may provide health information to:

- Other health care providers such as physicians, nurses, and therapists for purposes of referral or treatment;
- Public Health authorities with information on communicable diseases and vital records;
- Law enforcement when required by law;
- Coroners, medical examiners and funeral directors;
- Workers' Compensation agencies and self-insured employers for work-related illness or injuries;
- Appropriate individuals when we believe it necessary to avoid a serious threat to health or safety or to prevent serious harm to an individual;
- Government oversight agencies (including the FDA, Food & Drug Administration, and when otherwise required by law) with data for health oversight activities such as auditing or licensure;
- Researchers, if an IRB approves use and disclosure without patient authorization.

Your Rights

Your rights are listed below: If you would like to exercise any of these rights, inquire at the front desk or ask a staff member for the proper form.

1. **The right to inspect and receive copies:** You may request a copy of your records in writing by using the Macalester College Health Services Authorization for Disclosure of Health Information Form. You may be charged for copies provided.
2. **The right to request confidential communications:** You may request that we communicate with you about medical matters in a particular way or at a particular location.
3. **The right to request restricted use:** You may request in writing that we not use or disclose your information for certain purposes.
4. **The right to amend your record:** You may request to amend your record if you think it is incorrect or that important information is missing.
5. **The right to obtain an accounting of disclosures:** You may request to receive a list of certain instances when we have disclosed your health information.

Complaints or Questions

If you have questions about your privacy rights or believe they have been violated, you can file a complaint with:

Health and Wellness Director
Health and Wellness Center
Macalester College
1600 Grand Ave.
St. Paul, MN 55105
651-696-6275

OR

US Dept. of Health & Human Services
200 Independence Ave. SW
Washington, DC 20201
202-601-0257
Toll Free: 1-877-696-6775

I acknowledge that I have been provided with a copy of these Privacy Standards.

Signature

Date