

HEALTH AND COUNSELING SERVICES

The Diana B. Torrey '82 Health and Counseling Center

What services are provided at the Torrey Health and Counseling Center? We provide comprehensive and confidential mental and physical health care to all St. Lawrence University students. Services range from dealing with anxiety, depression and eating disorders to the treatment of illness and injury, gynecologic care and monitoring of students with chronic illness.

Where is the Torrey Center? The Center is located at 76 Park Street.

Who is eligible? Health and Counseling services are available to all students registered for credit-bearing courses at St. Lawrence University. Standard mental health and physical health services are free for those students.

When is the Torrey Center open? During the academic year, hours are Monday-Friday, 8:00 a.m.-4:30 p.m. After normal business hours, you can reach the counselor on call at 315-229-5555 or procure emergency medical services by calling 315-229-5555 or by dialing 911.

A student who has an urgent health care need that is not an emergency should go to the CPH After-Hours Clinic, next to campus in the E.J. Noble Center (315-386-3300). The nearest hospital with Emergency Department services is Canton-Potsdam Hospital, 50 Leroy Street, Potsdam (315-265-3300), a 15-minute drive from campus. Students needing transportation to the hospital should call 315-229-5555, for appropriate arrangements.

Does a student need an appointment to be seen at the Torrey Center? Unless it is an emergency situation, students are encouraged to schedule an appointment by calling 315-229-5391 for counseling-related appointments and 315-229-5392 for health-related appointments. We make every effort to schedule appointments that will not interfere with class attendance.

What if a student is ill and cannot attend class? Call or e-mail the professor before class to let him or her know that you will not be able to attend class that day. We do not provide "sick notes."

What are the most common illnesses students suffer in college? Colds, flu, infectious mononucleosis, bronchitis, urinary tract infection and strep throat are among the common illnesses treated. Lifestyle and close living quarters have a huge impact on students' immune response and frequency of illness. We encourage all students to get a flu shot every fall. The most common mental health issues seen in college students surround depression, anxiety, eating and body image, adjusting to college, and relationships (romantic, friends, and family-of-origin relationships).

Does the staff provide care for students with special or chronic health care needs? Yes, we will work with a student's personal physician as needed to ensure optimal health care. Private physicians may call or fax orders for laboratory or x-ray tests to our office, to be forwarded to Canton-Potsdam Hospital's ancillary services. It is helpful to us to have the student's medical records forwarded to us if we are assisting with a chronic problem. If a controlled drug is to be ordered by a practitioner at



St. Lawrence, the student's medical records from the initially prescribing physician must be in our office.

What if a student's needs cannot be met by the Torrey Center? Although we provide a wide range of care, we cannot offer some specialist services. When this occurs, referrals to appropriate practitioners and other health care providers within the community are provided.

Do parents have access to health information? Although parents may be paying for the student's college education, according to federal privacy laws (HIPPA, FERPA), they do not have the right to know if or why their son/daughter has visited the Torrey Center. If you are 18 years old or older and have given us written permission to discuss care with your parents, we can talk to them about the issue(s) mentioned on the Release of Information form signed by you. We cannot accept long-term, blanket Release of Information forms. Written permission needs to be given each time a student wants us to discuss care with his/her parents. Federal law requires this level of confidentiality.

What does it cost? Torrey Health and Counseling Center services are free to St. Lawrence University students. Students are charged for items such as immunizations, certain drugs and orthopedic appliances. Students obtaining such items at the Torrey Center will be provided a receipt to file a private insurance claim. We do not directly bill insurance companies. Fees incurred will be charged to the student's account through student financial services.

We do not have access to your health insurance information. If your HMO requires prior approval or authorization for services, the student will be responsible for calling his/her primary care provider. Students should have their own insurance card and have knowledge of their specific plan coverage.

What about student health insurance? All students are required to have either private insurance or insurance purchased through the University while attending St. Lawrence. St. Lawrence University, through Niagara National (www.niagaranational.com), representing Markel Insurance Company, provides a comprehensive Student Health Insurance Plan (a blanket accident and health insurance policy) available to all St. Lawrence students. All students are automatically enrolled in the plan provided by St. Lawrence. Refer to the Financial Information section for more information or instructions for waiving the St. Lawrence plan.

Other Health & Counseling Services

International Programs

Staff members counsel students who are going to Third World countries and offers the vaccinations required for travel. Information and consultations are also available on other international study programs. Students are asked to make an appointment with the travel nurse during the earlier stages of planning for their time abroad.

Allergy Clinic

Health service personnel will, in cooperation with their private doctor, help students continue ongoing allergy treatments by providing shots for immunotherapy. Your doctor must send the prescribed serum, with clearly written instructions for the administration of the serum. Appointments are needed for allergy shots. A health care provider must be in attendance when allergy injections are given. It is the student's responsibility to keep track of his/her injection schedule and to receive injections when due.

Sexual Health

Reproductive health, gender issues, sexual identities and disease prevention are important topics; we can help students negotiate the maze of sexual health matters by providing education, confidential testing and counseling as needed.

Laboratory/Radiology

The Torrey Center does not have lab or x-ray services on premises but can offer a full range of services through our relationship with Canton-Potsdam Hospital. Insurance will be billed directly by the hospital for services provided. Students should have their insurance information with them when referred to these ancillary services.

Pharmacy

The Torrey Center offers a limited supply of prescriptions and some over-the-counter medications. Most often, a prescription will be written to be filled at a local pharmacy. Canton pharmacies are:

Kinney Drugs	315-386-4563
P&C Pharmacy	315-379-9620
Rite Aid Pharmacy	315-386-8611

Please remember to present all pertinent insurance information to the pharmacist.

Other University Resources

(from off-campus or by cell phone, 315-229-xxxx)

Counseling Services	5391
Health Service	5392
Health and Counseling Center Fax	5514
Security and Safety	5555

Area Resources

Canton-Potsdam Hospital	315-265-3300
CPH After-Hours Clinic, E.J. Noble Center	315-386-3300
Canton Rescue Squad/Village Police	911
CAVA (Citizens Against Violent Acts)	315-386-3777
Reachout/Crisis Hotline	315-265-2422

Health Form Requirements

As a full-time incoming student attending St. Lawrence University you are required to submit the following documents for your student health file.

1. Student Health Form

This includes your:

- immunization record
- comprehensive physical exam report (*dated within the last 12 months*)
- health history

Side 1 of the health form **should be filled out by the student.**

Side 2 of the health form **must be completed and signed by your health care provider. The physical examination must be documented on our form.**

You must have a current PPD (TB skin test) administered, read, and dated within six (6) months prior to your arrival on campus.

2. Meningitis Response Form

This form must be completed and returned if you choose **not** to receive the meningitis vaccination.

We are required by law to include this form in your student health file.

The meningitis vaccination is not required, although it is recommended for all college students living on campus.

3. Privacy Practices Form

Federal law prohibits the release of your medical records, if you are 18 years of age or older, without your written consent. You will need to read the Notice of Privacy information and sign the Privacy Practices form.

All three forms should be mailed in the small envelope included with this guide so that they will be received at the Torrey Health Center. You will need to allow at least two weeks for the mail to reach us.

Remember that you will not be able to check into your room or attend classes until these forms have been received and all health requirements have been met.

For more information, call the Torrey Center at 315-229-5392.



Student Health Form - PAGE 1

(Front to be completed by student; back by health care provider)

The information on this form is confidential and will not be released to anyone without your knowledge and consent.

Approved	_____	_____	_____
	Date		NP
Not Approved	_____	_____	_____
	Date		NP

I. General Information *(please print)*

Name _____ Date of Birth ____/____/____ Cell phone (____) _____ Sex Male Female

Address _____
Street City State Zip

Parent/Guardian _____ Telephone (____) _____

Address _____
Street City State Zip

II. Health History – Family

Has anyone in the family ever had any of the following:

	Age	State of Health	Age at Death	Cause of Death <i>(if deceased)</i>	Yes	No	Relationship
Father:							
Mother:							
Brother(s):							
Sister(s):							

III. Health History – Personal

Have you ever had or do you now have (check yes or no):

	Yes	No		Yes	No
Chicken Pox			Psychiatric Disorders		
Hepatitis			Anxiety Reactions		
Infectious Mononucleosis			Chronic Skin Problems		
Tuberculosis or contact with Tuberculosis			Neurological Disorders		
Rheumatic Fever			Epilepsy		
Eye, Ear, Nose problem or injuries			Fainting Spells		
Heart Problem(s)			Head injury with unconsciousness		
Heart Murmur			Endocrine Disorder(s)		
High Blood Pressure			Diabetes Mellitus		
Irregular or Rapid Heart Beat			Anemia		
Pain or Pressure in the Chest			Allergies to Medications and/or Food		
Asthma			Physical Handicap(s)		
Significant Allergic Reaction(s)			Serious Accident(s)		
Chronic or Recurrent Gastrointestinal Problems			Operation(s)		
Kidney Problems			Have you been hospitalized?		
Hernia			Are you taking medication currently? (list)		
Eating Disorder			Other medical problems (please list)		
Mental Illness					

Please elaborate on any "Yes" answers on additional sheet(s) as necessary. Indicate diagnosis, treatment, if the condition is still present, or if you have recovered. Record any significant medical problems not covered in the above list.

Current Medication(s) and Dose(s) _____

IV. Clinical Evaluation

Height _____	Weight _____	BMI _____	Vision <i>Uncorrected</i> <i>Corrected</i>
Blood Pressure _____ / _____	Pulse _____	<i>Reg. / Irreg.</i>	<i>Right</i> 20/ _____ 20/ _____
Urinalysis: Alb. _____	Sugar _____	Micro _____ (<i>optional</i>)	<i>Left</i> 20/ _____ 20/ _____

Normal	Abnormal	Check each item in proper column (N.E. if not evaluated)	Give details of each abnormality.
		1. Head, Neck, Face, and Scalp	
		2. Nose and Sinuses	
		3. Mouth and Throat	
		4. Teeth and Gingiva	
		5. Ears (Perf. of drum, etc.), Hearing	
		6. Eyes (lids, conjunctiva, etc.)	
		7. Pupils and Ocular Motion	
		8. Lungs, Chest and Breasts	
		9. Heart (Note any restriction of activity)	
		10. Vascular System (Varicosities, etc.)	
		11. Abdomen and Viscera (include hernia)	
		12. Ano-rectal (pilonidal)	
		13. Endocrine System	
		14. G-U System	
		15. Upper Ex. (strength, range of motion)	
		16. Feet	
		17. Lower Ex. (as for upper)	
		18. Spine, other Musculo-skeletal	
		19. Skin and Lymphatics	
		20. Neurologic	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	21. Psychiatric (including personality deviations)	
		22. Is this student physically able to participate in intercollegiate athletics? <i>If not please elaborate on any contraindications or any medical or orthopedic conditions requiring further treatment:</i>	

V. Required Information

Within the past 6 months:
PPD: Date _____ Results _____ **OR Chest x-ray:** Date _____ (attach report)

Immunizations	Dates (mo,day,yr)	Dates (mo,day,yr)
Measles – Two immunizations, serology or physician-documented illness	____/____/____	Diphtheria/Pertussis/Tetanus (DPT) Series Completed
Mumps – Immunization or physician-documented illness	____/____/____	Tetanus/Diphtheria (TD) Booster within last 10 years
Rubella – Immunization or Rubella Titer	____/____/____	Polio – Series Completed
OR		Booster
MMR (Measles/Mumps/Rubella) (two immunizations)	____/____/____	____/____/____

Recommended

Hepatitis A vaccine (two shots) (indicate mo,day,yr) 1. ____/____/____ 2. ____/____/____

Hepatitis B vaccine (three shots) (indicate mo,day,yr) 1. ____/____/____ 2. ____/____/____ 3. ____/____/____

Meningococcal meningitis vaccine - *Check type:* Menomune Menactra (indicate mo,day,yr) ____/____/____

Quadrivalent HPV vaccine (indicate mo,day,yr) 1. ____/____/____ 2. ____/____/____ 3. ____/____/____

Printed Name of Examining Health Care Provider _____ Phone / fax _____ Date _____

Printed Address of Examining Health Care Provider _____ Signature of Examining Physician _____

Rev. 5/08

Meningococcal Meningitis Vaccine

Please Print

Name _____ Date of Birth ____/____/____

Address _____
Street City State Zip

Local/Cell Phone (Area Code): (____) _____

For all students regardless of age, New York State Public Health Law mandates that you read the following and sign the Meningococcal Meningitis response form below.

Meningitis disease is a severe bacterial infection of the bloodstream or meninges (a thin layer covering the brain and spinal cord). It is a relatively rare disease and usually occurs as a single isolated event. Clusters of cases or outbreaks are rare in the United States. It is transmitted through air via droplets of respiratory secretions and direct contact with an infected person. Direct contact, for these purposes, is defined as oral contact with shared items such as cigarettes or drinking glasses or through intimate contact such as kissing.

Although anyone can come into contact with the bacteria that cause meningococcal disease, data also indicates that certain social behaviors, such as exposure to passive and active smoking, bar patronage, and excessive alcohol consumption, may put students at increased risk for the disease. Patients with respiratory infections, compromised immunity, those in close contact to a known case, and travelers to endemic areas of the world are also at increased risk.

The early symptoms usually associated with meningococcal disease include fever, severe headache, stiff neck, rash, nausea, vomiting and lethargy, and may resemble the flu. Because the disease progresses rapidly, often in as little as 12 hours, students are urged to seek medical care immediately if they experience two or more of these symptoms concurrently. The disease is occasionally fatal. The symptoms may appear two to ten days after exposure, but usually within five days. Antibiotics can be used to treat people with meningococcal disease.

Only people who have been in close contact (household members, intimate contacts, health care personnel performing mouth-to-mouth resuscitation, day care center playmates, etc.) need to be considered for preventive treatment. Such people are usually advised to obtain a prescription for a special antibiotic from their physician. Casual contact as might occur in a regular classroom, office or factory setting is not usually significant enough to cause concern.

There is a vaccine that will protect against some strains of meningococcus. It is recommended in outbreak situations, and for those traveling to areas of the world where high rates of the disease are known to occur. The meningococcal vaccine has been shown to provide protection against the most common strains of the disease, including serogroups A, C, Y and W-135. The vaccine has been shown to be 85-100 percent effective in serogroups A and C in older children and adults. The vaccine is very safe and adverse reactions are mild and infrequent, consisting primarily of redness and pain at the site of injection lasting up to 2 days. If you wish to receive the meningococcal vaccine, contact your health care provider.

To be completed and signed by student or parent/guardian for students under age 18.

CHECK ONLY ONE (1) BOX

I (my child) had the meningococcal meningitis immunization within the last 10 years.

Date Received: ____/____/____

Type Received: check ONLY one (1) box Menomune Menactra

I have read the information regarding meningococcal meningitis disease and I understand the risk of not receiving the vaccine. I (my child) **will not** obtain the immunization against meningococcal meningitis disease at this time.

Signature _____

Date _____

Health Insurance Portability and Accountability Act (HIPAA)

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this notice, please contact the Health Center, 315-229-5392.

Who Will Follow This Notice

This notice describes our Health Center's practices and that of:

- any health care professional authorized to enter information into your chart;
- all employees, staff and other Health Center personnel;
- services provided in our organization through contacts with business associates and other University departments. Examples include physician services outside the University who may be used in consult, radiology and certain laboratory tests. To protect your health information, however, we require all University associates to appropriately safeguard your information.

Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the Health Center. We need this record to provide you with high quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the health service whether made by Health Center personnel or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category are listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians or other Health Center personnel who are involved in taking care of you at the Health Center. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive at a hospital or consulting physician may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about

surgery or tests you received at the hospital so your health plan will pay or reimburse you for the surgery. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the Health Center.

Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Individuals Involved in Your Care: We may release medical information about you to a friend or family member who is involved in your medical care only if they are appointed as your health care proxy or you give written authorization. We may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

As Required by Law: We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would be only to someone able to help prevent the threat.

Special Situations

Workers' Compensation: We may release medical information about you for Workers' Compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will make this disclosure only when required or authorized by law.

Health Oversight Activities: We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights law.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;

- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the University; and
- In emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

National Security and Intelligence Activities: We may release medical information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

Protective Services for the President and Others: We may use medical information about you to make decisions regarding your medical suitability for a security clearance or service abroad. We may also release your medical suitability determination to officials in the Department of State who need access to that information for these purposes.

Your Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and request a copy of your medical information that may be used to make decisions about your care. Usually, this includes medical records, but does not include psychotherapy notes. To inspect and request a copy of your medical information that may be used to make decisions about you, you must submit your request in writing. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another health care professional will review your request and the denial. The person conducting the review will not be the person who denied your request. The Health Center will comply with the outcome of the review.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Health Center. To request an amendment, your request must be made in writing and submitted to the Health Center. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us;
- Is not part of the medical information kept by or for us;
- Is not part of the information which you would be permitted to inspect and copy.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. HIPAA defines disclosure as "the release, transfer, provision of access to, or divulging in any manner of information outside the entity holding the information." This includes disclosures to or by business associates of the covered entity. Exclusions that do not require tracking include:

- Disclosures made for treatment, payment and health care operation purposes;
- Disclosures made to the individual;
- Disclosures made to persons involved in the individual's care;
- Disclosures made for national security or intelligence purposes;
- Disclosures to law enforcement officials;
- Disclosures made prior to the date of compliance with the privacy standards.

To request this list or accounting of disclosures, you must submit your request in **writing** to the Health Center. Your request must state a time period which may not be longer than six years and may not include dates before the HIPPA effective date (1996). Your request should indicate in what form you want the list (e.g., on paper, electronically) and where the list is to be sent.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a test you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Health Center. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your parents.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by phone, CMR or at home. To request confidential communications, you must make your request in **writing** to the Health Center. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Changes To This Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice at the Health Center. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register at the Health Center for treatment, we will offer you a copy of the current notice in effect.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Health Center. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in **writing**, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you for the legally specified amount of time.

Health Insurance Portability and Accountability Act (HIPAA)

Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this authorization. As provided in our notice, the terms of our notice may change. If we change our notice, you will be provided a new notice on your next date of service. You may also obtain a revised copy by contacting the Torrey Health Center.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this authorization, *in writing*, except where we have already made disclosures in reliance on your prior authorization. You are also acknowledging receipt of our Notice of Privacy Practices.

Student Signature

Date

Print Student Name

SLU ID #

Witness

Date