THE GRADUATE COLLEGE OF UNION UNIVERSITY
HEALTH DEGREE PROGRAMS

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.

The Graduate College of Union University, hereafter GCUU, has a structured curriculum of health programs, hereafter the Program, and as part of the Program students are required to have supervised patient contact at health care facilities licensed by the New York State Department of Health, hereafter the Clinical Affiliate.

GCUU and the Clinical Affiliate are required by law, including the provisions of the Health Insurance Portability and Accountability Act (HIPAA), to maintain the privacy of protected health information; to provide you with notice of their legal duties and privacy practices with respect to protected health information; and to abide by the terms of this notice. This notice is effective on the date that you sign this consent.

Protected health information means individually identifiable health information. GCUU and the Clinical Affiliate anticipate that during the course of this Program GCUU and the Clinical Affiliate will obtain health information which is identifiable with you.

To the extent that such information is obtained it will only be used as follows:

> To assure that you have the required vaccinations and that there are no health issues which would prevent you from participating in the Program; and
>
> For purposes of treatment in the event of a need by you for treatment.

In addition protected health information may be disclosed in accordance with federal or state statutory or regulatory requirements.

Other uses and disclosures of your protected health information will be made only with your further written authorization, which you may decline to give or which you may revoke, except to the extent that GCUU and the Clinical Affiliate have taken action in reliance on this consent or a subsequent consent or authorization. Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected.

Further you also have the following rights with respect to protected health information which may be exercised by a writing directed to the attention of the Registrar of GCUU.

- The right to revoke this consent;
- The right to request restrictions on certain uses and disclosures of protected health information, but GCUU and the Clinical Affiliate are not required to agree to a requested restriction;
- The right to receive confidential communications of protected health information by alternative means or at alternative locations;
- The right to inspect and copy protected health information;
- The right to amend protected health information, unless the information is accurate and complete; and
- The right to receive an accounting of disclosures of protected health information.

You may complain to the Registrar of GCUU and to the Secretary of the United States Department of Health and Human Services, if you believe that your privacy rights have been violated. You will not be retaliated against for filing a complaint.

For further information concerning your privacy rights contact:

The Vice President of Administration and Student Services
The Graduate College of Union University
807 Union St.
Schenectady, NY, 12308

Students Name:_________________________________

____
PRINT NAME

____
SIGNATURE OF STUDENT   DATE

____
PRINT NAME OF STAFF PERSON FACILITATING REQUEST

____
SIGNATURE OF STAFF PERSON FACILITATING REQUEST   DATE

This form must be signed and submitted to the Registrar's office in Lamont House. It is maintained in your academic file.

THE GRADUATE COLLEGE OF UNION UNIVERSITY
HEALTH DEGREE PROGRAMS
STUDENT CONSENT

The Graduate College of Union University, hereafter GCUU, has a structured curriculum of health programs, hereafter the Program, and as part of the Program students are required to have supervised patient contact at health care facilities licensed by the New York State Department of Health, hereafter the Clinical Affiliate.

I ACKNOWLEDGE AND AGREE AS FOLLOWS:

I understand and will respect the confidential nature of patient-specific data that is available to me.

I will comply with all policies and procedures of the Clinical Affiliate, including the need to maintain the confidentiality and security of patient health information,.

I understand that in order for me to participate in the Program, it is necessary for GCUU and the Clinical Affiliate to each have access and to share my health records. I understand that this release will include any and all health records that either GCUU or the clinical Affiliate may possess, including the following kinds of records to the extent that they exist or are created during the Program :

- Medication History;
- Treatment Recommendations
- Medical History;
- Assessment Information;
- Diagnosis;
- Treatment Progress;
- Results of Psychological Testing;
- Progress Notes;
- Discharge Summary;
- Drug Screen Results;
- Psychiatric Evaluation;

I understand that this information may be transmitted by mail, in person or verbally.

THIS AUTHORIZATION WILL REMAIN IN EFFECT SO LONG AS I AM ENROLLED AT GCUU UNLESS WITHDRAWN. I understand that this authorization may be withdrawn by me at any time in writing except to the extent that action has been taken, but that thereafter I will no longer be able to participate in the Program.

Student's Name: ____

____
PRINT NAME

____ ______________________
SIGNATURE OF STUDENT DATE

____
PRINT NAME OF STAFF PERSON FACILITATING REQUEST

____ ______________________
SIGNATURE OF STAFF PERSON FACILITATING REQUEST DATE

This form must be on file in the Registrar's office in Lamont House.
It is maintained in your academic file.

THE GRADUATE COLLEGE OF UNION UNIVERSITY
HEALTH DEGREE PROGRAMS
IMMUNIZATION DOCUMENTATION

The health degree programs at the Graduate College of Union University requires the completion of the course requirements listed in the Graduate College of Union University Catalog. It includes requirements that require patient contact at health care facilities licensed by the New York State Department of Health and designated by the course instructor.

As a condition to participate in patient contact at licensed health care facilities, a number of requirements must be complied with in accordance with requirements imposed by licensed health care facilities and the New York State Department of Health as set forth in Title 10 Part 405.3(10) of the New York Codes, Rules, and Regulations (NYCRR), including, but not limited to, the requirements listed below:

1. A physical examination and recorded medical history.
2. A certificate of immunization against rubella.
3. A certificate of immunization against measles.
4. A ppd (Mantoux) skin test for tuberculosis.

If these requirements are not satisfied or they are not otherwise waived by the sponsoring licensed health care facility or an exemption is not issued in accordance with applicable New York State Department of Health code, rules, and regulations, a student will not be permitted to participate in patient contact, and will therefore not be able to fulfill essential course requirements.

THE GRADUATE COLLEGE OF UNION UNIVERSITY
HEALTH DEGREE PROGRAMS
IMMUNIZATION DOCUMENTATION

Name (Print) ___________________________________ DOB:__________________

TO BE FILLED OUT BY PHYSICIAN Page 1

Chicken Pox/Varicella: Proof of immunity will mean two doses of varicella vaccine, a physician documented history of disease, and/or serologic evidence of immunity.

History of Varicella: Yes ___ No___
Immunization Date 1._____________ Date 2.__________
Titer: Date:_____________ Result:________________________

Rubella: Proof of rubella will mean one dose of rubella vaccine administered on or after the first birthday and/or serologic evidence of immunity.

History of Rubella: Yes _____ No_____
Immunization Date 1._____________
Titer: Date:_____________ Result:________________________

Rubeola (Measles): Proof of immunity to measles will mean two doses of live vaccine (after 1968) administered on or after the first birthday, separated by at least one month, physician documented history of disease, and/or serologic evidence of immunity. Measles, mumps and rubella (MMR) vaccine is the preferred vaccine for both diseases of measles immunization.

History of Rubeola: Yes _____ No_____
Immunization Date 1._____________
Titer: Date:_____________ Result:________________________

Mumps: Proof of mumps immunity will mean one dose of mumps vaccine administered on or after the first birthday, a physician documented history of disease, and/or serologic evidence of immunity.

History of Mumps: Yes _____ No_____
Immunization Date 1._____________
Titer: Date:_____________ Result:________________________

Tuberculosis Skin Test (PPD): Tuberculosis skin test is **required**.

Negative Test (within 1 year) Date: ______________
Positive test: Date:___________ Negative test (within 1-3 weeks of 1st : _______________
Positive test – requires chest x-ray: Date:_______________ Result:_______________
BCG – Date:_______________ INH – Date: ______________________

Hepatitis B Vaccine: Strongly Recommended. (can be declined, see below)

Date 1: ______________ Date 2:__________________ Date 3:)___________________
Titer: Date:_____________ Result:______________________________

I prefer not to have the Hepatitis B Vaccine at this time:
Student signature: ___________________________________ Date:________________

Meningococcal Meningitis – Check one of the following:

1. Had the meningococcal meningitis immunization (Menomune) with the past 10 years. Date received: ____________
2. Read, or have had explained to me, the information regarding meningococcal meningitis disease. I will obtain immunization against meningococcal meningitis with 30 days from my private health care provide or Union College Health Services.
3. Read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I will not obtain immunization against meningococcal meningitis disease.

Date of last **Physical**: _____________________

Physician name: __________________________________ Phone #: ( ) _________________

Address: ____
____

Physician Signature: __________________________________ Date:______________________

This form must be signed and submitted to the Registrar's Office in Lamont House.
A copy must also be on file at the Union College Health Office in Silliman.

THE GRADUATE COLLEGE OF UNION UNIVERSITY

HEALTH DEGREE PROGRAMS

IMMUNIZATION DOCUMENTATION

(Annual Physical) Page 2

Note: Completion of this assessment by a student health officer or physician is required prior to patient contact. (within one year)

_______________________________________ was examined on _______________

Name (Print) Date

and found to be physically and mentally fit to participate in direct contact within the scope of his/her activities as a student in the Health Programs of the Graduate College of Union University or its affiliates.

This student has the following limitation (if any):

____

____

____

COMMENTS: ____

____

Date: ________________

__________________________________ ______________________________

Health Officer/ Attending Physician (Print) Signature

This form must be signed and submitted to the Bioethics program office. A copy must also be on file at the Union College Health Office in Silliman.