

# Connecticut State University Student Health Services Form

Date Beginning School  Fall  Spring of \_\_\_\_\_

FOR OFFICE USE ONLY

Complete  Missing: \_\_\_\_\_

**PLEASE RETAIN A COPY OF THIS HEALTH FORM FOR YOUR RECORDS BOTH SIDES/PAGES OF THIS FORM MUST BE SUBMITTED**

Last Name	First Name	MI
Date of Birth and Birthplace:	Sex/Gender:	Student ID #: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

**State of Connecticut and Connecticut State Universities REQUIRE:**

**Two doses for each Measles, Mumps, Rubella & Varicella One dose of Meningitis\* Complete TB Risk and/or Test or Treatment**

Vaccine & Date Given	OR	Incidence of Disease	OR	Titer Test Results (attach lab report)	Requirements
1	Measles #1 <input type="checkbox"/> or MMR <input type="checkbox"/>	Date:		Measles Titer	<b>Must be</b> on or after 1 <sup>st</sup> birthday.
	Date:			Date:	
2	Mumps #1 <input type="checkbox"/> or MMR <input type="checkbox"/>	Date:		Mumps Titer	<b>Must be</b> on or after 1 <sup>st</sup> birthday.
	Date:			Date:	
3	Rubella #1 <input type="checkbox"/> or MMR <input type="checkbox"/>	Date:		Rubella Titer	<b>Must be</b> on or after 1 <sup>st</sup> birthday.
	Date:			Date:	
4	Varicella #1 <input type="checkbox"/> OR	Incidence of Disease Chicken Pox	OR	Varicella Titer	Varicella is required only for students born on or after January 1, 1980 #1 <b>Must be</b> on or after 1 <sup>st</sup> birthday; #2 <b>Must be</b> at least 28 days after 1 <sup>st</sup> immunization
	Varicella #2 <input type="checkbox"/>			Date:	
5				Meningococcal <input type="checkbox"/>	*Required only if living in university owned housing.
				Vaccine Type or Brand:	<input type="checkbox"/> I will not be living in University owned housing. I do not require this vaccine.
				Date:	

**6 TUBERCULOSIS (TB) RISK QUESTIONNAIRE - A through D To be answered by the Student**

A. Have you ever had a positive tuberculosis skin or blood test in the past?  Yes  No  
**If you answer, "Yes," Section 6b., "CHEST X-RAY", must be completed**

B. To the best of your knowledge have you ever had close contact with anyone who was sick with tuberculosis (TB)?  Yes  No

C. Were you born in one of the countries listed below? **If yes circle country**  Yes  No

D. Have you traveled or lived for more than one month in one or more of the countries listed below? **If yes circle country.**  Yes  No

Afghanistan, Algeria, Angola, Armenia, Azerbaijan, Bangladesh, Belarus, Benin, Bhutan, Bolivia, Bosnia & Herzegovina, Botswana, Brunei Darussalam, Burkina Faso, Burundi, Cambodia, Cameroon, Cape Verde, Central African Republic, Chad, China, China-Macao, China-Hong Kong, Congo, Congo DR, Cote d'Ivoire, Djibouti, Dominican Rep., Ecuador, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Georgia, Ghana, Guatemala, Guinea, Guinea-Bissau, Guyana, Haiti, Honduras, India, Indonesia, Iraq, Kazakhstan, Kenya, Kiribati, Korea-DPR, Korea-Rep, Kyrgyzstan, Lao PDR, Latvia, Lesotho, Liberia, Lithuania, TFYR, Madagascar, Malawi, Malaysia, Mali, Marshall Islands, Mauritania, Micronesia, Moldova-Rep, Mongolia, Morocco, Mozambique, Myanmar, Namibia, Nepal, Niger, Nigeria, Northern Mariana Islands, Pakistan, Papua New Guinea, Paraguay, Palau, Peru, Philippines, Qatar, Romania, Russian Federation, Rwanda, Sao Tome & Principe, Senegal, Sierra Leone, Solomon Islands, Somalia, South Africa, Sri Lanka, Sudan, Suriname, Swaziland, Taiwan, Tajikistan, Tanzania-UR, Thailand, Timor-Leste, Togo, Turkmenistan, Tuvalu, Uganda, Ukraine, Uzbekistan, Vanuatu, Vietnam, Yemen, Zambia, Zimbabwe  
Based on WHO Global TB Report 2009

**6.** If you answer **NO** to all questions no further action is required. **Prior BCG does not exempt patient from this requirement.**  
 If you answer **YES** to B-D of the above questions, Connecticut State University requires **that a healthcare provider** complete the following TB testing evaluation and x-ray **within 6 months prior to the start of classes.** (After February for Fall Semester and after July for Spring Semester.)

<b>6a. TB BLOOD TEST OR</b> <input type="checkbox"/> Interferon-gamma release assay Date: Result: <input type="checkbox"/> NEG <input type="checkbox"/> POS	<b>6a. TB SKIN TEST</b> Use 5TU Mantoux test only. <b>TB skin tests ARE NOT ACCEPTED from other countries.</b> Date Planted: Date Read: Interpretation (If no induration, mark 0) <input type="checkbox"/> NEG <input type="checkbox"/> POS _____ mm of induration	<b>6b. CHEST X-RAY</b> Required within 6 months for past or current positive TB skin or blood test. <b>X-ray report MUST BE ATTACHED</b> Chest X-ray Date: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<b>6c. TB TREATMENT MEDICATION (with dose):</b> Frequency: Start & Completion Dates:
--	--	--	--

**Other Vaccination History** (Tetanus Booster within last 10 years and Hepatitis B series are recommended)

Hepatitis B #1 Date	Hepatitis B #2 Date	Hepatitis B #3 Date	Hepatitis Titer Date	Result: <input type="checkbox"/> POS <input type="checkbox"/> NEG
Last Tetanus Booster: Td <input type="checkbox"/> or Tdap <input type="checkbox"/>	Other Vaccination:	Other Vaccination:	Other Vaccination:	
Date:				

**Signatures**

**I confirm that the information above is accurate.**  
**Clinician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Physical Examination Affirmation:** I have examined this patient on \_\_\_\_\_ and find no medical condition that would prohibit him/her from participating fully in all activities including physical education, trying out for competitive sports or military training and employment.  
**Clinician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Consent for treatment required to be signed** (if you are less than 18 years of age signatures of both the student and one parent/guardian are required)  
 I hereby grant permission for the Connecticut State University Health Services staff to provide me with appropriate medical and mental health treatment including medications for treatment of illnesses/injuries and to arrange for any emergency medical care if circumstances at that time make it impossible for me to make such decisions. Furthermore, I understand that University Health Services staff may disclose my student medical records and/or information from such records to appropriate University personnel and/or Emergency Contacts identified within my records in the event of a health or safety situation as determined by the Student Health Services staff.  
**Signature of Student** \_\_\_\_\_ **Signature of Parent/Guardian** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Connecticut State University Student Health Services Form**

**Page 2**

**PLEASE RETAIN A COPY OF THIS HEALTH FORM FOR YOUR RECORDS BOTH SIDES/PAGES OF THIS FORM MUST BE SUBMITTED**

Student Name	Home/Personal Email Address	Student Cell Phone
--------------	-----------------------------	--------------------

Permanent Home Information			Notify in Case of Emergency		
Home Phone	Cell/Work Phone		Name	Relationship	
Street Address			Home Phone		
			Cell/Work Phone		
City	State	Zip	Street Address		
			City	State	Zip
Personal Physician/Healthcare Provider			Address:		
Name:			Telephone #:		
			FAX #		

**Personal Medical History- Please circle all below that apply to you**

Check here if none apply

- |                                   |                           |                      |
|-----------------------------------|---------------------------|----------------------|
| Alcohol/drug Abuse                | Diabetes                  | Mumps                |
| Anxiety/depression/mental illness | Endometriosis             | Rheumatic Fever      |
| Asthma                            | Gastrointestinal Problems | Seizures             |
| Cancer                            | Hepatitis B or C Disease  | Sickle Cell Anemia   |
| Cardiac Condition/Heart Murmur    | High Blood Pressure       | Thyroid Disorder     |
| Coagulation Disorder              | HIV/AIDS                  | Tuberculosis         |
| Concussion                        | Measles                   | Other please explain |
| Dental Problems                   | Mononucleosis             |                      |

**Allergies: Drugs & Other Severe Adverse Reactions - Please complete all that apply and explain reaction**

Check here if you have no allergies

Medication	Food
Insect	Environmental
Seasonal	X-ray Contrast
<b>Are any life threatening?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Do you carry an Epi Pen?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No

Prior Hospitalizations or Surgeries - Please list dates and reasons

Medications – Frequent or regular- Please list all prescriptions, natural and over the counter medications

Is there any other medical information or health concern that we should know about? Please attach any additional information to further explain your condition or concern.

Current Height\*\*:

Current Weight\*\*:

Last Blood Pressure (if known)\*\*:

**\*\*not required**

**Did you sign the Consent for Treatment on Page 1?**

Please return by mail or fax to the appropriate Health Service listed below.

Central Connecticut State University  
University Health Service  
1615 Stanley Street  
New Britain, CT 06050  
860/832-1925 Fax 860/832-2579

Eastern Connecticut State University  
University Health Service  
185 Birch Street  
Willimantic, CT 06226  
860/465-5263 Fax 860/465-4560

Southern Connecticut State University  
University Health Service  
501 Crescent Street  
New Haven, CT 06515  
203/392-6300 Fax 203/392-6301

Western Connecticut State University  
University Health Service  
181 White Street  
Danbury, CT 06810  
203/837-8594 Fax 203/837-8583

## Connecticut State University Immunization Requirements

State of Connecticut General Statutes/ **Section 10a-155** regulations requires all matriculated students born after December 31, 1956, to provide proof of adequate immunization against measles (rubeola), rubella, mumps and varicella (chicken pox) before permitting such students to enroll.

*Proof of immunity to **Measles- (Rubeola)**-this means you must provide proof of the following:*

- 1<sup>st</sup> dose of measles must be on or after 12 months of age
- 2<sup>nd</sup> dose must be at least 28 days from 1<sup>st</sup> dose **OR**
- **Two MMR OR**
- Documentation (actual lab result) of positive titer (blood test)

*Proof of immunity to **Rubella**-this means you must provide proof of the following:*

- 1<sup>st</sup> dose of Rubella must be on or after 12 months of age
- 2<sup>nd</sup> dose must be at least 28 days from 1<sup>st</sup> dose **OR**
- **Two MMR OR**
- Documentation (actual lab result) of positive titer (blood test)

*Proof of immunity to **Mumps**- this means you must provide proof of the following:*

- 1<sup>st</sup> dose of Mumps must be on or after 12 months of age
- 2<sup>nd</sup> dose must be at least 28 days from 1<sup>st</sup> dose **OR**
- **Two MMR OR**
- Documentation (actual lab results) of positive titre (blood work)

*Proof of immunity to **Varicella (chicken pox)**-this means you must provide proof of the following:*

- 1<sup>st</sup> dose of Varicella must be on or after 12 months of age
- 2<sup>nd</sup> dose must be at least 28 days from 1<sup>st</sup> dose
- Documentation (actual lab results) of positive varicella titer (blood test)
- Exemption for transfer & graduate students
- Exemption if born in the USA before 1/1/1980

**OR**

*Certification of confirmed case of measles, mumps, rubella & varicella by a licensed health care provider may be submitted in lieu of the above.*

### **IMMUNIZATION EXEMPTIONS:**

- Students born prior to January 1, 1957 are **exempt** by age to the measles, mumps, rubella & varicella requirement.
- The University will only permit vaccination waivers for religious or medical reasons.  
*Exemptions for either medical or religious reasons subjects the individual to exclusion from campus in the event of an outbreak of a disease for which immunizations are required.*
  - *Exemption waiver form is available for download*  
[www.wcsu.edu/healthservices/onlineforms.asp](http://www.wcsu.edu/healthservices/onlineforms.asp)
- *Distance learning programs conducted entirely through electronic media in a setting without other students present are exempt.*
- *Graduation from a Connecticut High School in or after 1999 NO LONGER MEETS the requirement for immunization proof*
- **Meningitis/Menactra** administered within the past five years is required for all campus residents prior to room assignment
- **Hepatitis B:** American College Health, Public Health Department, and Centers for Disease Control recommend students be immunized for Hepatitis B (*this is not required*).