GUIDELINES FOR THE CSU HEALTH FORM

- **Parts A and C:** These sections to be filled out by student. Please complete part 'C' before your physical exam so that your health care provider can review this section with you.

- **Part D:** All students must complete the tuberculosis screening process. Please go to this section of the health form for further instructions.

  NOTE: INTERNATIONAL STUDENTS – TUBERCULIN SKIN TESTING (PPD) RESULTS WILL ONLY BE ACCEPTED IF DONE AT OUR OFFICE OR AT ANOTHER UNITED STATES FACILITY.

- **Part E: This section is to be filled out by the student's health care provider. A PHYSICAL EXAMINATION** must be done within a year prior to entering our University.

- **Part B: IMMUNIZATIONS:** Please provide the dates of the immunizations listed in this section. If there are minor differences in our guidelines from your high school or state, please follow our requirements outlined below.

  1. **Tetanus** Immunizations – list the childhood series. Tetanus booster (Td) – required within the past 10 years.

  2. **Polio** Immunizations – list the childhood series.

  3. **German measles (Rubella) Vaccination** – one dose given on or after the student's first birthday. Required by Connecticut state law. (This immunization is included in the MMR vaccine.)

  4. **Mumps Vaccination** – one dose given on or after 12/28/69. (This immunization is included in the MMR vaccine.)

  5. **Two Measles (Rubeola)** – required by Connecticut state law. (This immunization is included in the MMR vaccine.)

     a. **First Measles Vaccination** – on or after student's first birthday AND given after January 1, 1969.
     b. **Second Measles Vaccination** – on or after January 1, 1980.
     Please note:
     - If you did not receive your first measles shot in accordance with the guidelines, then two shots must be administered after January 1, 1980 and no less than 30 days apart.
     - **If you have had measles or rubella as a child or you think you did, we will accept proof of this only with a blood test showing evidence of adequate immunity. You must provide a copy of the actual test results.**
     - EXEMPTION: You do not need to show proof of measles immunizations if you were born before 1957.

  6. **Hepatitis B Vaccination Series** – not required but strongly recommended. We offer any one or all doses at our health service to enable you to complete the series of three shots. Please see hepatitis information sheet included in this packet. **Varicella** (chickenpox) – please consider this vaccine if you have not had chickenpox yet.

  7. **MENOMUNE ("MENINGITIS") VACCINE** – required by Connecticut state law for all students living in campus housing but recommended for all incoming students. A student's housing assignment will be forfeited if Health Services does not receive proof of the meningitis vaccine by the end of the first week of classes. Please see our website for more information on meningitis and the vaccine.

The completed health form must be submitted prior to the start of classes.

THE HEALTH EXAMINATION REPORT SUBMITTED TO THE UNIVERSITY IS CONFIDENTIAL AND WILL NOT BE RELEASED TO ANYONE WITHOUT WRITTEN CONSENT FROM THE STUDENT.

Central Connecticut State University	Eastern Connecticut State University	Southern Connecticut State University	Western Connecticut State University
University Health Service	University Health Service	University Health Service	University Health Service
860/832-1925	860/465-5263	203/392-6300	203/837-8594

For office use only. Date received: __________ CSU ID #: ____________ Missing information: ________________________

PLEASE RETURN TO THE APPROPRIATE UNIVERSITY HEALTH SERVICE

Central Connecticut State University	Eastern Connecticut State University	Southern Connecticut State University	Western Connecticut State University
University Health Service 1615 Stanley Street New Britain, CT 06050 860/832-1925 Fax 860/832-2579	University Health Service 185 Birch Street Willimantic, CT 06226 860/465-5263 Fax 860/465-4560	University Health Service 501 Crescent Street New Haven, CT 06515 203/392-6300 Fax 203/392-6301	University Health Service 181 White Street Danbury, CT 06810 203/837-8594 Fax 203/837-8583

Connecticut State University Health Service
Confidential Health Form

- ❑ ***PLEASE USE ATTACHED GUIDELINES FOR COMPLETING THIS HEALTH FORM.***
- ❑ ***MAKE A COPY OF THIS FORM BEFORE SUBMITTING IT TO THE UNIVERSITY.***

Entering semester: ☐ Fall ☐ Spring Year: ☐

PART A

LAST NAME	FIRST NAME			SOCIAL SECURITY # ____/____/________
BIRTH DATE ____/____/____	BIRTH PLACE			HOME PHONE (____) ____-________
PERMANENT HOME ADDRESS STREET ________________ APT ______ CITY ____________ STATE ______ ZIP ______				STUDENT CELL PHONE (IF AVAILABLE) (____) ____-________ SEX: ☐ MALE ☐ FEMALE
FATHER'S LAST , FIRST NAME	PHONE #	MOTHER'S LAST, FIRST NAME		PHONE #
FATHER'S ADDRESS (IF DIFFERS FROM ABOVE)		MOTHER'S ADDRESS (IF DIFFERS FROM ABOVE)		
GUARDIAN'S LAST, FIRST NAME	PHONE #	SPOUSE./PARTNER LAST , FIRST NAME		PHONE #
GUARDIAN'S ADDRESS		SPOUSE /PARTNER ADDRESS		

PART B: IMMUNIZATION HISTORY

DIPHTHERIA/TETANUS/PERTUSSIS	DTP (INITIAL SERIES) ____/____/____ , ____/____/____ , ____/____/____ , ____/____/____ TETANUS BOOSTERS (*RECOMMENDED EVERY TEN YEARS*) ____/____/____ , ____/____/____
POLIO SERIES	1ST ____/____/____ 2ND ____/____/____ 3RD ____/____/____
GERMAN MEASLES (RUBELLA) OR MMR#1	IMMUNIZATION DATE ____/____/____ OR , IF ANTIBODY TITER, PLEASE PROVIDE COPY OF ACTUAL LAB RESULTS.
MEASLES (RUBEOLA) OR MMR #1 AND #2	BOTH VACCINATION DATES MUST BE LISTED: DATE ____/____/____ (*FIRST IMMUNIZATION AT OR AFTER 12 MONTHS OF AGE AND IN OR AFTER 1969*) DATE ____/____/____ (*SECOND IMMUNIZATION REQUIRED ON OR AFTER 1/1/80*) OR, IF ANTIBODY TITER, PLEASE PROVIDE COPY OF ACTUAL LAB RESULTS.
MUMPS OR MMR #1	NATURAL DISEASE OR IMMUNIZATION DATE ____/____/____
HEPATITIS B SERIES (*highly recommended*)	1ST ____/____/____ 2ND ____/____/____ 3RD ____/____/____
MENINGITIS VACCINE	DATE ____/____/____ *REQUIRED FOR ALL RESIDENCE HALL STUDENTS*
VARICELLA (*recommended)*)	NATURAL DISEASE ___/___ (MO/YR) or VACCINE DATES ___/___/___ , ___/___/___ OR, IF ANTIBODY TITER, ACTUAL COPY OF LAB RESULTS

PART C : REVIEW OF HEALTH HISTORY

Please check all items that apply to you. Explain YES responses in space provided below.

SKIN	Yes	No	RESPIRATORY	Yes	No	GENITOURINARY	Yes	No	MUSCULOSKELETAL	Yes	No	ENDOCRINE	Yes	No
Acne			Asthma			Urinary Tract Infections			Arthritis			Diabetes		
Other Skin Problems			Chronic Cough			Kidney Stones or Disease			Fractures or Dislocations			Sudden Weight Change		
EYES			Bronchitis or Pneumonia			Sexually Transmitted Infection			Back/Disc Problems			Overweight		
Blindness			Do you smoke?			**Women:**			Curvature of the spine			Thyroid Problems/Disease		
Eye Injury/Disease			**CARDIAC**			Menstrual Irregularity			Disease of the Joints			**HEMATOLOGIC**		
Wears Contacts/Glasses			High Blood Pressure			Disabled By Cramps			Paralysis			Easy Bruising		
Color Blindness			High Cholesterol			Abnormal Pap Smear			**NEUROLOGICAL**			Anemia/ low iron		
EARS/NOSE/THROAT			Irregular Heart Rate			PMS			Migraines			Sickle Cell Trait/Disease		
Hearing Loss/ Deafness			Heart Murmur			Breast Problems			Frequent Headaches			Clotting Disorder		
Frequent Ear Infections			History of Palpitations			Breast Surgery			Concussion			**INFECTIOUS DISEASE**		
Perforated Eardrum			Chest Pain			Pelvic Inflammatory Disease			Severe Head Injury			Chicken Pox		
Repeated Nosebleeds			**GASTROINTESTINAL**			Gyn Surgery			Dizziness/Fainting			Mononucleosis		
Sinus Infections			Stomach Problems/ Ulcer			**Men:**			Insomnia			Whooping Cough		
Frequent Sore Throats			Requires Special Diet			Epididymitis			Neuromuscular Disorder			Malaria		
Tonsils/Adenoids Surgery			Hepatitis			Testicular Torsion			Seizures/Epilepsy			Meningitis		
DENTAL			Gallbladder Problems			Loss/Damaged Testicle			**MENTAL HEALTH**			**HOSPITALIZATION/ SURGERY**		
Bleeding Gums			Irritable Bowel Problems			Undescended Testicle			Anxiety Disorder			**OTHER PROBLEMS**		
Poor teeth			Hemorrhoid Problems			Testicular Cancer			Clinical Depression					
Wisdom Teeth Extraction			Appendectomy						Anorexia and/or Bulimia					
			Hernia						Suicide Attempt					

EXPLAIN each 'yes' response including dates where appropriate. Please use an extra page if space is not adequate.

____

____

____

CURRENT MEDICATIONS

NAME	DOSAGE AND DOSING SCHEDULE

ALLERGIES: Please list all allergies and type of reactions that occur.

Medication Allergy ______________________

Environmental/ Seasonal Allergy ______________________

Insect or Bee Allergy: ______________________

Food Allergy: ______________________

FAMILY HISTORY ☐ If adopted , please check box and skip this section.

	Age	Health Good/ Poor	Age at time of death	Cause of death	Alcoholism	Allergies/Asthma	Anemia/Bleeding disorder	Arthritis	Cancer	Diabetes	Eating disorders	Epilepsy/Seizure disorder	Emotional/ mental disease	Genetic disorder	Heart disease	High Blood pressure	Kidney/bladder problem	Migraines	Neurological disorder	Suicide or attempt	Stomach disease	Stroke	Tuberculosis
FATHER																							
MOTHER																							
SIBLING																							
SIBLING																							
SIBLING																							
SIBLING																							

SIGNATURES REQUIRED:

- I certify to the best of my knowledge that the information on this form is complete and correct.

  SIGNATURE OF STUDENT ______________________ DATE: ____/____/____

- I consent to medical treatment by the University Heath Service.

  SIGNATURE OF STUDENT (18 YEARS OLD OR OLDER) ______________________ DATE: ____/____/____

CONSENT FOR MINOR (UNDER 18 YEARS OF AGE): I give my permission for medical treatment for my daughter/son if accident/illness should occur while she/he is a student at a Connecticut State University System campus. This would include referral to a local hospital which may result in her/his hospitalization, anesthesia, and surgery should it be necessary and I am unable to be reached.

PARENT/ GUARDIAN'S NAME (PLEASE PRINT) ______________________ RELATIONSHIP ____________

SIGNATURE OF PARENT/GUARDIAN ______________________ Date ____/____/____

PART D: Tuberculosis (TB) Risk Assessment

The Connecticut State University (CSU) System requires all incoming students, regardless of age, to complete a Tuberculosis Risk Assessment to provide documentation of TB risk. To be reviewed with your health care provider.

Patient (student) to answer the following questions:

	YES	NO
1. To the best of your knowledge, have you ever had close contact with anyone who was sick with tuberculosis (TB)?		
2. Were you born in one of the countries listed below?		
3. Have you traveled or lived for more than one month in one or more of the the countries listed below?		
4. Do you have diabetes, kidney disease, immunocompromised diseases including HIV/AIDS, silicosis, chronic steroid therapy or a history of the following: substance abuse, cancer, pulmonary fibrotic lesions on x-ray, gastrectomy or jejunoileal bypass surgery?		
5. Have you ever had a positive tuberculosis skin test in the past?		

Afghanistan, Angola, Armenia, Azerbaijan , Bahamas, Bahrain, Bangladesh, Belarus, Benin, Bhutan, Bolivia, Bosnia-Herzegovina, Botswana, Brazil, Brunei, Darussalam, Burkina Faso, Burundi, Cambodia, Cameroon, Cape Verde, Central African Rep., Chad, China -Hong Kong SAR, China -Macao SAR, Columbia, Comoros, Congo, DR, Cote d'Ivoire, Croatia, Djibouti, Dominican Rep., Ecuador, El Salvador, Equatorial Guinea, Eritrea, Estonia, Ethiopia, Gabon, Gambia, Georgia, Ghana, Guam, Guatemala, Guinea, Guinea-Bissau, Guyana, Haiti, Honduras, Hungary, India, Indonesia, Iran, Iraq, Japan, Kazakhstan, Kenya, Kiribati, Korea, DPR, Korea, Rep., Kyrgyzstan, Lao PDR, Latvia, Lesotho, Liberia, Lithuania, Macedonia, TFYR, Madagascar, Malawi, Maldives, Mali, Marshall Islands, Mauritania, Mauritius, Mexico, Micronesia, Moldova Rep., Mongolia, Morocco, Mozambique, Myanmar, Namibia, Nepal, New Caledonia, Nicaragua, Niger, Nigeria, Northern Mariana Islands, Pakistan, Palau, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Poland, Portugal, Qatar, Romania, Russian Federation, Rwanda, Sao Tome & Principe, Saudi Arabia, Senegal, Serbia & Montenegro, Seychelles, Sierra Leone, Singapore, Solomon Islands, Somalia, South Africa, Sri Lanka, Sudan, Suriname, Swaziland, Syrian Arab Rep., Taiwan, Tajikistan, Tanzania UR, Thailand, Timor-Leste, Togo, Turkey, Turkmenistan, Uganda, Ukraine, Uzbekistan, Vanuatu, Venezuela, Vietnam, Yemen, Zambia, Zimbabwe.

*World Health Organization Global Tuberculosis Control, WHO Report 2003

- **If the answer is YES to any of the above questions, the CSU System requires that a healthcare provider complete the TB testing evaluation below within 6 months prior to the start of classes.**
- **If the answer is NO to all of the above questions, no TB testing or further action is required and the section below DOES NOT need to be completed.**

Tuberculosis (TB) Testing Evaluation

NOTE: Previous BCG vaccine does not exempt the student from this requirement and a chest x-ray is not an acceptable substitute for a PPD.* *TO INTERNATIONAL STUDENTS – TUBERCULIN SKIN TESTING MUST BE DONE AT OUR OFFICE OR ANOTHER U.S. FACILITY

If the student answered YES to any of questions 1 – 4 above, a PPD test is required within 6 months prior to the start of classes. If the PPD is positive, a chest x-ray is required and must be done within 6 months prior to the start of classes.

If the student has had a previous positive PPD (answered YES to question # 5 above), a new PPD is not necessary. A chest x-ray is needed within 6 months prior to the start of classes unless the student has been treated. If the student has been treated in the past, please complete treatment section below.

Tuberculin Skin Test: ***Use 5TU Mantoux test only. Multiple puncture test such as Tine is not accepted.***

Date Planted:	Result: (after 48-72 hours): _____ mm induration (If no induration, please put "0" mm)	Interpretation: ☐ NEGATIVE ☐ POSITIVE
Date Read:		

IF TB SKIN TEST POSITIVE (currently or in the past):

Chest x-ray: ☐ Normal ☐ Abnormal – please describe	Date of x-ray:
Treatment: ☐ Yes ________________________ (drug, dose, frequency, dates, location) ☐ No	
I certify that this student has completed TB testing. Healthcare provider signature: ____________________ Date: ______________	Address:

PART E: THIS SECTION TO BE COMPLETED BY THE STUDENT'S HEALTH CARE PROVIDER.

A PHYSICAL EXAMINATION IS REQUIRED WITHIN ONE YEAR PRIOR TO ENROLLMENT.

STUDENT NAME: ______________________ (PLEASE PRINT) DATE OF BIRTH: ______________

WGT. ______ HT. ______ BP ______ P ______

VISION: (CORRECTED) RIGHT 20/ ____ LEFT 20/ ____

HEARING: RIGHT ____________ LEFT ____________ METHOD USED __________

SYSTEM	NORMAL	DESCRIBE ABNORMAL FINDINGS
GENERAL APPEARANCE		
SKIN		
HEENT		
NECK, THYROID		
CHEST		
LUNGS		
HEART (DESCRIBE MURMUR, CLICK)		
ABDOMEN		
GENITOURINARY (HERNIAS –MALES ONLY)		
MUSCULOSKELETAL (EXTREMITIES, BACK, SPINE)		
LYMPHATIC		
NEUROLOGICAL		
PSYCHOLOGICAL		

If clinically indicated from history or physical exam
DATE
URINALYSIS
SP. GR:
Glucose:
Protein:
Blood:
BLOOD
Hgb/Hct:

TUBERCULOSIS SCREENING - **PLEASE GO TO PRECEDING PAGE FOR TB SCREENING PROCEDURE.**

LIST ALL ALLERGIES (INCLUDING MEDICATIONS, INSECT VENOM, ETC.) ______________________

COMMENT ON TYPE OF REACTION (I.E. RASH, HIVES, ANAPHYLAXIS) ______________________

LIST ALL MEDICATIONS CURRENTLY BEING TAKEN ______________________

____

COMMENT ON SPECIAL DIETARY REQUIREMENTS ______________________

STATUS OF STUDENT'S PHYSICAL RESTRICTIONS ☐ UNRESTRICTED ☐ PARTIAL RESTRICTION ☐ FULL RESTRICTION

COMMENT ______________________

STATUS OF STUDENT'S HEALTH ☐ EXCELLENT ☐ GOOD ☐ POOR COMMENT ______________________

PRINT: HEALTH PROVIDER'S NAME ______________________ (LAST, FIRST) TELEPHONE # (___) ____ - ______

ADDRESS ______________________ (STREET, CITY, STATE, ZIP)

HEALTH PROVIDER'S SIGNATURE ______________________ DATE OF EXAMINATION ___/___/___

(This medical certificate will be on file in the University Health Service)