Connecticut State University Student Health Services Form

Date Beginning School ☐ Fall ☐ Spring of _____(year)_____

FOR OFFICE USE ONLY
☐ Complete ☐ Missing: _____

PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS – BOTH SIDES/PAGES OF THIS FORM MUST BE COMPLETED AND SUBMITTED

Last Name	First Name	MI
Date of Birth and Birthplace:	Sex/Gender:	Student ID #:

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 ☐ or ☐ MMR Date:	Date:	Measles Titer Date:	***Must be*** **on or after 1st birthday.**
	Measles #2 ☐ or ☐ MMR Date:		Result: ☐ Pos ☐ Neg	***Must be*** **at least 28 days after 1st immunization.**
2	Mumps #1 ☐ or ☐ MMR Date:	Date:	Mumps Titer Date:	***Must be*** **on or after 1st birthday**
	Mumps #2 ☐ or ☐ MMR Date:		Result: ☐ Pos ☐ Neg	***Must be*** **at least 28 days after 1st immunization.**
3	Rubella #1 ☐ or ☐ MMR Date:	Date:	Rubella Titer Date:	***Must be*** **on or after 1st birthday**
	Rubella #2 ☐ or ☐ MMR Date:		Result: ☐ Pos ☐ Neg	***Must be*** **at least 28 days after 1st immunization.**
4	Varicella #1 Date: Varicella #2 Date:	Incidence of Chicken Pox Disease OR Date: Provider Initials:	Varicella Titer Date: Result: ☐ Pos ☐ Neg	Varicella required only for students born on or after January 1, 1980 #1 Must be on or after 1st birthday; #2 Must be at least 28 days after 1st immunization
5	Meningococcal (must include groups A,C,Y&W-135) If living on-campus, your last vaccination must be within 5 years of your 1st day of school. Date(s): 1. _____ 2. _____ Name of Vaccine: _____ ☐ I will not be living on-campus. I do not require this vaccine			
6	TUBERCULOSIS (TB) RISK QUESTIONNAIRE –QUESTIONS A THROUGH D TO BE ANSWERED BY STUDENT			
	A. Have you ever had a positive TB skin or blood test in the past? If you answer, "Yes," Section 6b., CHEST X-RAY, must be completed			☐ Yes ☐ No
	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,Anguilla,Argentina,Armenia,Azerbaijan,Bahrain,Bangladesh,Belarus,Belize,Benin,Bhutan,Bolivia,(Plurinational,State,of),Bosnia,and,Herzegovina,Botswana,Brazil, Brunei,Darussalam,Bulgaria,BurkinaFaso,Burundi,Cambodia,Cameroon,Cape,Verde,Central,African,Republic,Chad,China,China,Hong,Kong,Special,Administrative,Region,China,Macao,Special, Administrative,Region,Colombia,Comoros,Congo,Côte,d'Ivoire,Democratic, People's Republic of Korea Democratic Republic of the Congo, Djibouti, Dominican Republic, Ecuador, El Salvador, Equatorial,Guinea,Eritrea,Estonia,Ethiopia,Fiji,French,Polynesia,Gabon,Gambia,Georgia,Ghana,Guam,Guatemala,Guinea,GuineaBissau,Guyana,Haiti,Honduras,India,Indonesia,Iraq,Iran,Japan Kazakhstan,Kenya,Kiribati,Kuwait,Kyrgyzstan,Lao,People's,Democratic,Republic,Latvia,Lesotho,Liberia,Libyan,Arab,Jamahiriya,Lithuania,Madagascar,Malawi, Malaysia, Maldives, Mali, Marshall,Islands,Mauritania,Mauritius,Mexico,Micronesia,(Federated,States,of),Mongolia,Morocco,Mozambique,Myanmar,(Burma),Namibia,Nauru,Niue,Nepal,Netherlands,Antilles,New, Caledonia, Nicaragua,Niger,Nigeria,Northern,Mariana,Islands,Pakistan,Palau,Panama,Papua,New,Guinea,Paraguay,Peru,Philippines,Poland,Portugal,Qatar,Republic,of,Korea,Republic of Moldova, Romania, Russian Federation, Rwanda, Saint Vincent and the Grenadines,Sao,Tome,and,Principe,Senegal,Serbia,Seychelles,Sierra,Leone,Singapore,Solomon,Islands,Somalia,South Africa, South Sudan, Sri Lanka, Sudan, Suriname, Swaziland, Syrian, Arab Republic, Tajikistan, Taiwan, Thailand, The former Yugoslav Republic of Macedonia, Timor-Leste, Togo, Trinidad and Tobago, Turks,and,Caicos,Islands,Tunisia,Turkey,Turkmenistan,Tuvalu,Uganda,Ukraine,United,Republic,of,Tanzania,Uruguay,Uzbekistan, Vanuatu, Venezuela,(Bolivarian, Republic of) Vietnam, Wallis, and, Futuna Islands, Yemen, Zambia, Zimbabwe. **Based on WHO Global TB Report 2013**

6. IF you answer **NO** to all questions no further action is required. ***Prior BCG vaccine 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.)**

6a. TB BLOOD TEST OR	6a. TB SKIN TEST Use 5TU Mantoux test only.		6b. CHEST X-RAY Required within 1 year for past or current positive TB skin or blood test. *X-RAY REPORT MUST BE ATTACHED*	6c. TB TREATMENT Medication/Dose
Interferon-gamma release assay Date: Result: ☐ NEG ☐ POS	Date Planted: Date Read:	Interpretation (If no induration, mark 0) ☐ NEG ☐ POS _____mm of induration	Chest X-ray Date: ☐ Normal ☐ Abnormal	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: ☐ Pos ☐ Neg
Last Tetanus Booster: Td or Tdap Date:	Other Vaccination:	Other Vaccination:	Other Vaccination:

I confirm that the information above is accurate.

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	
Name:	Address: Telephone #: FAX #

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

☐ **Check here if none apply**

Alcohol/drug Abuse	Diabetes	Mumps
Anemia	Endometriosis	Rheumatic Fever
Anxiety/Depression/Mental Illness	Gastrointestinal Problems	Seizures
Asthma	Hepatitis B or C Disease	Sickle Cell Disease
Cardiac Condition/Heart Murmur	High Blood Pressure	Thyroid Disorder
Bleeding/blood clot 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**

Medication	Food
Insect	Environmental (pollen, animals, etc.)
Seasonal	X-ray Contrast
Are any *life threatening?* ☐ **Yes** ☐ **No**	**Do you carry an Epi Pen?** ☐ **Yes** ☐ **No**

☐ **Check here if you have no allergies**

Prior Hospitalizations or Surgeries - Please list dates and reasons:

Medications (Frequently or regularly taken) - 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**: Most recent 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 Univ
University Health Service
501 Crescent Street
New Haven, CT06515
203/392-6300 Fax 203/392-6301

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

(Rev. 8/2015)

COMPLETE AND RETURN TO: WCSU.MEDICATCONNECT.COM OR HEALTHSERVICES@WCSU.EDU