IMMUNIZATION RECORD

Forms must be fully completed. Incomplete forms will be returned

(rev. 5/2010)

University of Hartford, Student Health Services
200 Bloomfield Avenue ♦ West Hartford, CT 06117 ♦ Phone: (860) 768-6601 Fax: (860) 768-5140

Name:_____ **Address:** Street:_____

UHA ID#:_____**SS#**_____ City:_____

Date of Birth: _____ Male _____ Female _____ State:_____ Zip_____

Student # (Cell) _____**Phone (Home)**_____

Status: Will be living in campus housing? ☐Yes ☐No Date Entering University: _____

☐Full-Time ☐Part-Time ☐Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐Graduate Program

***Exempt if born before 12/31/56*—contact the office to request an exemption.**

☐ REQUIRED IMMUNIZATIONS ☐

This section must be completed by either a physician or someone operating under the direction of a physician, i.e., school nurse, PA, APRN.

Disease History *IS NOT* acceptable	1st dose (or 1st MMR)	2nd dose (or 2nd MMR)	***OR***	Lab evidence of immunity—titer is acceptable Date:	
Measles					
Mumps					
Rubella					

As of August 1st 2010, 2 Varicella (chicken pox) immunizations (at least 28 days apart), physician recorded diagnosis, or lab evidence of immunity to Varicella is required of all incoming students.

Disease History acceptable	1st dose	2nd dose	***OR***	Lab evidence of immunity Date:	Titer:
Varicella					
OR Date of physician confirmed disease:					

Baseline test or current Tuberculosis Screening is required for ALL STUDENTS

Complete appropriate section (A or B) below:

A) ☐ Student was born outside the United States **and/or** has had the BCG vaccine in the past. If YES to this question, it is *required* that the student have a blood test (e.g. Quantiferon Gold TB test) instead of the skin test. BCG vaccines will interfere with the skin test. Country of Birth: _____

☐Quantiferon Gold-TB test Date: ____/____/____ Results: ☐Negative ☐Positive

B) ☐ Student was born in the United States **and** has never had the BCG vaccine.

☐PPD (Mantoux) Date: ____/____/____ Results: ☐Negative ☐Positive Induration ___ mm

☐Chest x-ray (if positive PPD) Date: ____/____/____ Results: ☐Negative ☐Positive

☐If positive PPD, treatment with _____ Dates: _____

All students living in CAMPUS HOUSING are required to have meningitis immunization.

Meningitis Vaccine Date: _____

(*Please complete ALL areas)*

Name: _____ DOB: _____ Student ID: _____

NON-REQUIRED, BUT STRONGLY RECOMMENDED IMMUNIZATIONS

Hepatitis A Vaccine Date 1: __/__/__ Date 2: __/__/__

Hepatitis B Vaccine Date 1: __/__/__ Date 2: __/__/__ Date 3: __/__/__

Tetanus Diphtheria Date: __/__/__ **HPV**: Date 1: __/__/__ #2: __/__/__ #3: __/__/__

Date of Last Physical Examination: _____ (***a physical is not required but strongly recommended)***

Signature of Health Care Provider: **(MUST BE SIGNED OR STAMPED BY HEALTHCARE PROVIDER)**

Name: _____ Signature: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ Fax: (_____) _____

The above sections must be completed by either a physician or someone operating under the direction of a physician, i.e., school nurse, PA, APRN. Student or Parent may not fill out above. All forms without signature or stamp will be returned.

Student/Parent--Please complete your portions of this form even if you are attaching another immunization form.

Continue….please complete all pages

(*Please complete ALL areas)*

Name: _____DOB: _____Student ID:_____

MEDICAL HISTORY

NOTIFICATION OF SPECIAL MEDICAL CONSIDERATIONS*: in an effort to be productively responsive to students needs, the University Health Services would like to be alerted to any special medical conditions or concerns that may require special attention or care. Please attach or forward any medical records that may be needed in order to provide appropriate care to this student while they are at college. Also, since we cannot automatically assume responsibility for a student's care without their willing participation, please instruct them to contact the Student Health Services office to make an appointment when needed.*

Current Medical History/Condition(s): _____

_____

_____

_____

Allergies/Allergens: _____

_____

_____

Medications Taken Regularly: (name/dosage) _____

_____

_____

_____

Medical History: Check if you have ever had any of the following. Comment on all checked conditions in the space below:

YES	NO		YES	NO	
☐	☐	Acne (under treatment)	☐	☐	Alcohol/drug use, problem or treatment
☐	☐	Anxiety	☐	☐	Anemia
☐	☐	Arthritis	☐	☐	Asthma
☐	☐	Bipolar disorder	☐	☐	Bleeding trait
☐	☐	Blood disorder	☐	☐	Breast disease
☐	☐	Cancer	☐	☐	Cerebral palsy
☐	☐	Chicken Pox	☐	☐	Chronic Bronchitis/emphysema
☐	☐	Crohn's Disease/IBS	☐	☐	Chronic kidney condition
☐	☐	Depression	☐	☐	Diabetes (type I or II)
☐	☐	Digestive trouble	☐	☐	Eating disorder (anorexia/bulimia)
☐	☐	Emotional/mental illness	☐	☐	Fracture/sprains
☐	☐	Hay fever	☐	☐	Hepatitis
☐	☐	Heart Disease	☐	☐	High Cholesterol
☐	☐	HIV/AIDS	☐	☐	Insomnia/sleep problems
☐	☐	Kidney stones	☐	☐	Menstrual problems
☐	☐	Migraine/recurrent headaches	☐	☐	Pelvic infection
☐	☐	Peptic ulcer	☐	☐	Phlebitis
☐	☐	Pregnancy	☐	☐	Rheumatic fever
☐	☐	Seizure disorder (epilepsy)	☐	☐	Sexually transmitted disease
☐	☐	Skin disorder	☐	☐	Systemic lupus
☐	☐	Thyroid disorder	☐	☐	Tobacco use
☐	☐	Urinary infection	☐	☐	Other:_____

If you answered yes to any of the above, please explain: _____

_____

_____

(*Please complete ALL areas)*

Name: _____ DOB: _____ Student ID: _____

Insurance Information

(Only for laboratory or x-ray services/referrals—Student Health Services <u>does not</u> utilize insurance. Students pay for medications and/or laboratory services done on site. Fees are payable at the time of service by cash, check, charge or the University Hawk Flex card)

Name of Insurance: _____

Policy Number: _____ **Group Number:** _____

Policy Holder: _____

Is prior authorization required for referrals? _____ **Laboratory Services?** _____

We use Quest Lab for all of our testing. We have full lab resources available onsite. Quest Lab picks up from us daily. If your insurance does not allow you to use Quest, please check here _____.
It will be the patient's responsibility to notify the provider about their insurance.
Please remember to send your student with a current copy of their insurance card.

Please provide any other additional information you feel would be needed in case of an emergency or health related situation: _____

_____

_____

_____

_____

Emergency Contact Information:

_____

_____

_____

Parents: Please note that if your student is over 18, we cannot discuss any health information with you without the student's written consent. The consent must be completed at the time of the visit(s) while at the Student Health Services office. Thank you for your understanding of the confidential nature of medical information.

Please make sure all sides are filled out completely and designated forms are signed by your medical provider. All forms must be at the Student Health office two weeks <u>PRIOR</u> to moving onto or attending classes to comply with The State of Connecticut's Department of Public Health's mandate.

The University does not permanently store these records. Please keep a copy for your permanent records.
To reduce unnecessary paper copies, please do not mail and fax—only send one completed copy.
Thank you for your prompt attention