PLEASE RETURN TO THE APPROPRIATE UNIVERSITY HEALTH SERVICE

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
181White Street
Danbury, CT 06810
203/837-8594 Fax 203/ 837-8583

Connecticut State University Health Service
Confidential Health Form

State of Connecticut General Statute regulations requires all full and part-time matriculated students, born after December 31, 1956, to provide proof of adequate immunization against measles (rubeola), German measles (rubella), chicken pox (varicella), and mumps before permitting such students to enroll. See attached guidelines for full details.

PLEASE RETAIN A COPY OF THIS FORM

Entering semester: ☐ Fall ☐ Spring year: 20 _____

PART A

LAST NAME	FIRST NAME		STUDENT ID NUMBER
BIRTH DATE _____/_____/_____	BIRTH PLACE		HOME PHONE (_____) _____-_____
PERMANENT HOME ADDRESS STREET _____ APT: _____ CITY _____ STATE _____ ZIP _____			STUDENT CELL PHONE (_____) _____-_____ SEX: ☐ MALE ☐ FEMALE
PARENT, GUARDIAN OR SPOUSE CONTACT INFORMATION (CIRCLE ONE)	LAST NAME	FIRST NAME	PHONE
STREET ADDRESS (IF DIFFERS FROM ABOVE)	CITY, STATE AND ZIPCODE		

PART B: IMMUNIZATION HISTORY

DTP, TD OR TDAP: (ADULT) BOOSTER _____/_____/_____ *CIRCLE ONE* *(UPDATED WITHIN PAST 10 YEARS)*	**POLIO SERIES** 1ST____/____/____ 2ND____/____/____ 3RD____/____/____
MMR # 1 AND # 2 OR LAB CONFIRMED IMMUNITY OR CERTIFICATE OF DISEASE	MMR #1 DATE _____/_____/_____ #2 DATE _____/_____/_____ OR **ATTACH LAB RESULT TO THIS FORM SHOWING IMMUNITY TO MEASLES, RUBELLA AND MUMPS *OR*** **ATTACH CERTIFICATE OF DISEASE FROM PHYSICIAN OR HEALTH DEPARTMENT FOR MEASLES, MUMPS AND RUBELLA**
MENINGOCOCCAL VACCINE ("MENINGITIS" VACCINE)	DATE _____/_____/_____ *REQUIRED FOR ALL RESIDENCE HALL STUDENTS*
HEPATITIS B SERIES (*highly recommended*)	1ST _____/_____/_____ 2ND _____/_____/_____ 3RD _____/_____/_____
HUMAN PAPILLOMA VACCINE	#1 _____/_____/_____ #2 _____/_____/_____ #3_____/_____/_____
VARICELLA VACCINE OR LAB CONFIRMED IMMUNITY OR CERTIFICATE OF DISEASE	VACCINE DATES: #1 ____/____/____ #2 ____/____/____ OR **ATTACH LAB RESULT SHOWING IMMUNE STATUS OR** **ATTACH CERTIFICATE OF DISEASE FROM PHYSICIAN OR HEALTH DEPARTMENT**

PART C: HEALTH HISTORY (MUST BE COMPLETED)

If you have had any of the following, please check 'yes'. Explain YES answers in the space provided.

	Yes		Yes		Yes		Yes		Yes
SKIN		**RESPIRATORY**		**GENITOURINARY**		**MUSCULOSKELETAL**		**ENDOCRINE**	
MRSA/boils		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		Weight issues	
Blindness		Do you smoke?		**Women:**		Scoliosis		Thyroid Problems/Disease	
Eye Injury/Disease		**CARDIAC**		Menstrual Irregularity		Disease of the Joints		**HEMATOLOGIC**	
Wears Contacts/Glasses		High Blood Pressure		Severe 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		Staph infection	
Repeated Nosebleeds		**GASTROINTESTINAL**		Gyn Surgery		Dizziness/Fainting		Mononucleosis	
Sinus Infections		Stomach Problems/ Ulcer		**Men:**		Insomnia		HIV	
		Requires Special Diet		Epididymitis		Neuromuscular Disorder		Malaria	
Tonsils/Adenoids Surgery		Hepatitis		Testicular Torsion		Seizures/Epilepsy		Meningitis	
DENTAL		Gallbladder Problems		Loss/Damaged Testicle		**MENTAL HEALTH**		HIV/AIDS	
Bleeding Gums		Irritable Bowel Problems		Undescended Testicle		Anxiety/Depression		**HOSPITALIZATIONS**	
Poor teeth		Hemorrhoid Problems		Testicular Cancer		Attention Deficit Disorder		List dates:	
Wisdom Teeth Extraction		Appendectomy				Anorexia and/or Bulimia		**SURGERY**	
		Hernia				Suicide Attempt			

DESCRIBE details for each 'yes' with dates. Please use an extra page if space is not adequate

_____

_____

_____

CURRENT MEDICATIONS

NAME	DOSAGE AND DOSING SCHEDULE
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES: ☐ No known drug allergies.
List allergy and describe reaction that occurs

Medication Allergy: _____
Environmental/ Seasonal Allergy: _____
Insect or Bee Allergy: _____
Food Allergy: _____

FAMILY HISTORY: If you are adopted or do not know your family history check here: ☐

Has any member of your immediate family had any of the following?

Anemia/Blood Disorder/Sickle Cell Disease_____ Cardiovascular Disease (Heart Attack or Stroke)_____ High Blood Pressure_____ Cancer _____

Addiction or Mental Illness_____ Tuberculosis_____ Diabetes_____ Kidney Disease_____ Asthma/Allergies_____ Thyroid Disease_____

Other relevant family history: _____

SIGNATURE(S) REQUIRED:

I hereby authorize the staff of a Connecticut State University System Health Service to provide medical treatment and services to me as they deem appropriate. This authorization will remain in effect as long as I am a student in the CSU System. In the case of a minor (under 18) a parent or legal guardian's signature below permits the student to obtain health care in the absence of the guardian.

STUDENT NAME (PLEASE PRINT) _____

STUDENT SIGNATURE: _____ 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 _____/_____/_____

STUDENT NAME: _____ (PRINT)

PART D: TUBERCULOSIS (TB) RISK ASSESSMENT:

SECTION I: TO BE FILLED OUT BY THE STUDENT; SECTION II: TO BE FILLED OUT BY THE HEALTH CARE PROVIDER.

SECTION I: *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 countries listed below?		
4. Do you have Diabetes, Kidney Disease, Immune System Diseases, including HIV/AIDS, Silicosis, chronic steroid therapy or a history of the following: substance abuse, cancer, pulmonary fibrotic lesions on x-ray, Gastrectomy, Jejunoileal bypass surgery?		
5. Have you ever had a positive tuberculosis skin test in the United States?		

COUNTRIES WITH HIGH RATES OF TUBERCULOSIS (TB) World Health Organization, Global Tuberculosis control. WHO report 2008
Afghanistan, Algeria, Angola, Anguilla, Argentina, Armenia, Azerbaijan, Bahamas, Bahrain, Bangladesh, Belarus, Belize, Benin, Bhutan, Bolivia, Bosnia & Herzegovina, Botswana, Brazil, Brunei Darussalam, Bulgaria, Burkina Faso, Burundi, Cambodia, Cameroon, Cape Verde, Central African Republic, Chad, China, Columbia, Comoros, Congo, Congo DR, Cote d'Ivoire, Croatia, Djibouti, Dominican Republic, Ecuador, Egypt, El Salvador, Equatorial Guinea, Eritrea, Estonia, Ethiopia, Fiji, French Polynesia, Gabon, Gambia, Georgia, Ghana, Guam, Guatemala, Guinea, Guinea-Bissau, Guyana, Haiti, Honduras, India, Indonesia, Iran, Iraq, Japan, Kazakhstan, Kenya, Kiribati, Korea-DPR, Korea-Rep, Kuwait, Kyrgyzstan, Lao PDR, Latvia, Lesotho, Liberia, Lithuania, Macedonia-TFYR, Madagascar, Malawi, Malaysia, Maldives, Mali, Marshall Islands, Mauritania, Mauritius, Mexico, Micronesia, Moldova-Rep, Mongolia, Montenegro, Morocco, Mozambique, Myanmar, Namibia, Nauru, Nepal, New Caledonia, Nicaragua, Niger, Nigeria, Niue, Northern Mariana Islands, Pakistan, Palau, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Poland, Portugal, Qatar, Romania, Russian Federation, Rwanda, St. Vincent & the Grenadines, Sao Tome & Principe, Saudi Arabia, Senegal, Seychelles, Sierra Leone, Singapore, Solomon Islands, Somalia, South Africa, Spain, Sri Lanka, Sudan, Suriname, Syrian Arab Republic, Swaziland Tajikistan, Tanzania-UR, Thailand, Timor-Leste, Togo, Tokelau, Tonga, Tunisia, Turkey, Turkmenistan, Tuvalu, Uganda, Ukraine, Uruguay, Uzbekistan, Vanuatu, Venezuela, Vietnam, Wallis & Futuna Islands, West Bank & Gaza Strip, Yemen, Zambia, Zimbabwe

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SECTION II: TO BE FILLED OUT BY THE HEALTH CARE PROVIDER *Tuberculosis (TB) Testing Evaluation:*

- **IF THE ANSWER IS YES** to questions 1-5 above, 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 PPD skin test is positive or has been positive in the past a chest x-ray is required and must be done within 6 months prior to the start of classes.

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 (MANTOUX Skin Test).*

FOR INTERNATIONAL STUDENTS *– TUBERCULIN SKIN TESTING MUST BE DONE IN OUR UNIVERSITY HEALTH OFFICE or ANOTHER UNITED STATES MEDICAL FACILITY.*

Tuberculin Skin Test: ***Use 5TU Mantoux test or IGRA(Quantiferon-TB). Tine is not accepted.***

Date Planted: ___/____/____	RESULT: *(after 48-72 hours)*: _____ mm induration *If no induration, please put "0" mm* INTERPRETATION: _____ POSITIVE _____ NEGATIVE Read by: _____ (signature)
Date ___/____/____	IGRA (QFT-G or QFT-GIT) _____POSITIVE ____ NEGATIVE

IF TB SKIN TEST POSITIVE- (currently or in the past) A CHEST X-Ray is required

Chest x-ray: __Normal __Abnormal – please describe Date of x-ray:

Treatment: No ____
Yes _____
(drug, dose, frequency, dates, location)

PART E: This page to be completed by the student's HEALTH CARE PROVIDER.

PHYSICAL EXAMINATIONS PERFORMED WITHIN ONE YEAR OF ENROLLMENT WILL BE ACCEPTED

STUDENT NAME: _____ DATE OF BIRTH: _____
NAME OF STUDENT (PRINT)

WGT. _____ HT. _____ BP _____ P _____

VISION: RIGHT 20/ _____ LEFT 20/ _____ WITH GLASSES: RIGHT 20/ _____ LEFT 20/ _____

HEARING: RIGHT _____ LEFT _____ METHOD USED _____

SYSTEM	NORMAL	DESCRIBE IF ABNORMAL
GENERAL APPEARANCE		
SKIN		
HEENT		
NECK, THYROID		
CHEST, BREASTS		
LUNGS		
HEART		
ABDOMEN		
GENITOURINARY		
MUSCULOSKELETAL		
LYMPHATIC		
NEUROLOGICAL		
PSYCHOLOGICAL		

If clinically indicated from history or physical exam; required for Division I athletes only
DATE
URINALYSIS
SP. GR:
Glucose:
Protein:
Micro:
DATE :
HGB/HCT

TUBERCULOSIS SCREENING: *PLEASE SEE PART "D" SECTION II FOR SCREENING GUIDELINES.*

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

COMMENT ON TYPE OF REACTION (I.E. RASH, URTICARIA, 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 _____

I HAVE REVIEWED AND COMPLETED THE TUBERCULOSIS SCREEINING SECTION OF THIS FORM. I CONFIRM THE IMMUNIZATIONS LISTED IN PART B.

PRINT: HEALTH PROVIDER'S NAME_____TELEPHONE# (_____) _____-_____

ADDRESS _____ _____ _____ _____
STREET CITY STATE ZIP

HEALTH PROVIDER'S SIGNATURE_____ DATE OF EXAM_____

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

Connecticut State University Immunization Requirements

State of Connecticut General Statutes regulations requires all students born after December 31, 1956, to provide proof of adequate immunization against measles (rubeola), rubella, varicella, and mumps before permitting such students to enroll.

The following are required for ALL students:

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

- Two measles or two MMR immunizations (one after your 1st birthday and one at least one month later)
- 1st dose of measles must be on or after 12 months of age and after **1969**
- 2nd dose must be after **1/1/1980 OR**
- Documentation (actual lab result) of positive titer (blood test)

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

- Rubella after 1st birthday and on or after 6/9/67 **OR**
- Documentation (actual lab result) of positive titer (blood test)

*Proof of immunity to **Varicella** (chicken pox) will be required for all incoming students **beginning** August 1, 2010:*

- Two varicella immunizations, **OR**
- Documentation (actual lab results) of positive varicella titer (blood test)
- ***EXEMPT** if born in the USA before 1/1/1980*

*Proof of immunity to **Mumps**, will be required for all incoming students **beginning** August 1, 2010:*

- Two mumps immunizations, **OR**
- Two MMR
- Documentation (actual lab results) of positive titre (blood work)

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

*Proof of **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*).

IMMUNIZATION EXEMPTIONS

- Students born prior to January 1, 1957 are exempt by age to the **measles**, **mumps**, **rubella** & **varicella** requirement.
- Students born before January 1, 1980 in the USA are exempt from providing proof of **varicella**
- 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*
- *Online learners do not need to meet the immunization requirements*
- *Proof of graduation from a CT high school in or after 1999 will be acceptable as proof of immunity to measles, mumps, and rubella only – **NOT** varicella.*

updated 3/10