Date received: office use only:_____ College Student ID: Missing Information _____

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

Connecticut State University Health Service
Confidential Health Form

PLEASE MAKE A COPY OF THIS FORM BEFORE SUBMITTING IT TO THE UNIVERSITY HEALTH SERVICE.

PLEASE USE ATTACHED GUIDELINES FOR COMPLETING THE MEDICAL FORM

THE CSU HEALTH FORM IS REQUIRED TO BE COMPLETED PRIOR TO REGISTRATION.
Parts A, B, and C are to be completed by the student prior to being examined by the physician, a nurse practitioner or physician assistant.

Entering semester: ☐ Fall ☐ Spring year: ☐ 20 ___

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/PERTUSSIS/TETANUS	DPT (INITIAL SERIES) _____/_____/_____ _____/_____/_____ _____/_____/_____ TD (ADULT) BOOSTER (*UPDATED WITHIN 10 YEARS TO DATE*) _____/_____/_____
POLIO SERIES	1ST _____/_____/_____ 2ND _____/_____/_____ 3RD _____/_____/_____
MMR # 1 AND # 2	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*)
MENINGOCCOCAL VACCINE ("MENINGITIS" VACCINE)	DATE _____/_____/_____*REQUIRED FOR ALL RESIDENCE HALL STUDENTS*
HEPATITIS B SERIES (*highly recommended*)	1ST _____/_____/_____ 2ND _____/_____/_____ 3RD _____/_____/_____
VARICELLA	NATURAL DISEASE ___/____(MTH/YR) VACCINE DATES ____/____/____; ____/____/_____OR TITER RESULT _____DATE _____/_____/_____

PART C: REVIEW OF SYSTEMS

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**		**MUSCULOSKELE**		**ENDOCRINE**	
Acne		Asthma		Urinary Tract		Arthritis		Diabetes	
Other Skin		Chronic Cough		Kidney Stones or		Fractures or		Sudden Weight	
EYES		Bronchitis or		Sexually Transmitted		Back/ Disc		Overweight	
Blindness		Do you smoke?		**Women:**		Scoliosis		Thyroid	
Eye Injury/Disease		**CARDIAC**		Menstrual Irregularity		Disease of the Joints		**HEMATOLOGIC**	
Wears		High Blood Pressure		Disabled By Cramps		Paralysis		Easy Bruising	
Color Blindness		High Cholesterol		Abnormal Pap Smear		**NEUROLOGICAL**		Anemia/ low iron	
EARS/NOSE/THR		Irregular Heart Rate		PMS		Migraines		Sickle Cell	
Hearing Loss/		Heart Murmur		Breast Problems		Frequent Headaches		Clotting Disorder	
Frequent Ear		History of		Breast Surgery		Concussion		**INFECTIOUS**	
Perforated Eardrum		Chest Pain		Pelvic Inflammatory		Severe Head Injury		Chicken Pox	
Repeated		**GASTROINTESTIN**		Gyn Surgery		Dizziness/Fainting		Mononucleosis	
Sinus Infections		Stomach Problems/		**Men:**		Insomnia		Whooping Cough	
Frequent Sore		Requires Special Diet		Epididymitis		Neuromuscular		Malaria	
Tonsils/Adenoids		Hepatitis		Testicular Torsion		Seizures/Epilepsy		Meningitis	
DENTAL		Gallbladder Problems		Loss/Damaged		**MENTAL**		**HOSPITALIZATIO**	
Bleeding Gums		Irritable Bowel		Undescended Testicle		Anxiety Disorder		**OTHER**	
Poor teeth		Hemorrhoid Problems		Testicular Cancer		Clinical Depression			
Wisdom Teeth		Appendectomy				Anorexia and/or			
		Hernia				Suicide Attempt			

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

_____

_____

_____

CURRENT MEDICATION

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 and do not know your family's medical history, please check here ____.

Relationship	age	health good/ poor	Age at 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.

  STUDENT NAME (PLEASE PRINT) _____

  STUDENT SIGNATURE : _____ DATE _____/_____/_____

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

  STUDENT SIGNATURE (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 ____/_____/_____

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 <u>for more than one month</u> in one or more of 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 United States?		

COUNTRIES WITH HIGH RATES OF TUBERCULOSIS (TB)

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.

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

- **IF THE ANSWER IS YES** to questions 1-4 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, a chest x-ray is required and must be done within 6 months prior to the start of classes.

  Question # 5: If your patient has had a previous positive PPD and answered YES to question # 5 above:

  1. A new PPD is not required.
  2. <u>A chest x-ray is required</u> and results are submitted in the appropriate box below.
  3. If the student has been treated or is undergoing treatment, please complete the treatment section below.

- **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.

***<u>NOTE</u>**: Previous BCG vaccine <u>does not exempt</u> the student from this requirement and a chest x-ray is not an acceptable substitute for a PPD (MANTOUX Skin Test).*

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

Tuberculin Skin Test: ***Use 5TU Mantoux test only. Multiple puncture test such as Tine is not accepted.***		
Date Planted: ___/___/____	Date Read: ___/____/____	RESULT: *(after 48-72 hours)*: _____mm induration *If no induration, please put "0" mm* INTERPRETATION: ___POSITIVE ___NEGATIVE Read by: _____(signature)

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.

A PHYSICAL EXAMINATION REQUIRED WITHIN ONE YEAR PRIOR TO ENROLLMENT AT THE UNIVERSITY

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 _____

PRINT: HEALTH PROVIDER'S NAME _____ TELEPHONE # (_____) _____-_____
LAST FIRST

ADDRESS _____ _____ _____ _____
STREET CITY STATE ZIP

HEALTH PROVIDER SIGNATURE _____ DATE OF EXAMINATION _____/_____/_____
(This medical certificate will be on file in the University Health Service)

GUIDELINES FOR THE CSU HEALTH FORM

STUDENT SECTIONS OF THE MEDICAL 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:** There are two sections to this page. Section I is to be filled out by the student. 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.

HEALTH PROVIDER SECTION OF THE FORM:

- **Part D:** Section II of this part is to be filled out by the student's health provider.

- **Part E:** 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.

INFORMATION FOR THE IMMUNIZATION PORTION OF THE FORM

If there are minor differences in our guidelines from your state, you must comply with our requirements.

- **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. **MMR –(MEASLES, MUMPS, RUBELLA)** The combination trivalent vaccine may be listed in the appropriate spaces provided.

4. **Rubeola (Measles) Two vaccines** – 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 vaccinations must be administered after January 1, 1980 and no less than 30 days apart.

   - **If you have had Rubeola or Rubella as a child** or uncertain about immunity status**,** you must provide documentation of immunity from a blood test. We require a copy of this laboratory test to be submitted with the health form.
   - **EXEMPTION for Rubeola:** A date or blood titer is not necessary if you were born before 1957.

5. **Rubella** (**German Measles) 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.)

6. **Meningococcal ("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 Service does not receive proof of the meningitis vaccine by the first day of classes. Please see our website for more information on meningitis and the vaccine.

7. **Hepatitis B Vaccination Series** – not required but strongly recommended. Check your campus to inquire whether the health service offers any one or all doses to enable you to complete the vaccine series.

8. **Varicella** (chickenpox) – please consider this vaccine if you have not had a history of chickenpox as a child.

The completed health form must be submitted prior to registration.