Connecticut State University Student Health Services Form

Date Beginning School ☐Fall ☐ Spring of _____

FOR OFFICE USE ONLY
☐ Complete ☐ Missing: _____

PLEASE RETAIN A COPY OF THIS HEALTH FORM FOR YOUR RECORDS BOTH SIDES/PAGES OF THIS FORM MUST BE 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 ☐ ***OR*** Date: Varicella #2 ☐ Date:	***OR*** Incidence of Disease Chicken Pox Date: Provider Initials:	Varicella Titer Date: Result ☐Pos ☐ Neg	Varicella is 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 ☐ Vaccine Type or Brand: Date :		*Required only if living in university owned housing. ☐ I will not be living in University owned housing. I do not require this vaccine.	

6 TUBERCULOSIS (TB) RISK QUESTIONNAIRE - A through D To be answered by the Student

A. Have you ever had a positive tuberculosis 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, Armenia, Azerbaijan, Bangladesh, Belarus, Benin, Bhutan, Bolivia, Bosnia & Herzegovina, Botswana, Brunei Darussalam, Burkina Faso, Burundi, Cambodia, Cameroon, Cape Verde, Central African Republic, Chad, China,China-Macao, China-Hong Kong, Congo, Congo DR, Cote d'Ivoire, Djibouti, Dominican Rep., Ecuador, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Georgia, Ghana, Guatemala, Guinea, Guinea-Bissau, Guyana, Haiti, Honduras, India, Indonesia, Iraq, Kazakhstan, Kenya, Kiribati, Korea-DPR, Korea-Rep, Kyrgyzstan, Lao PDR, Latvia, Lesotho, Liberia, Lithuania, TFYR, Madagascar, Malawi, Malaysia, Mali, Marshall Islands, Mauritania, Micronesia, Moldova-Rep, Mongolia, Morocco, Mozambique, Myanmar, Namibia, Nepal, Niger, Nigeria, Northern Mariana Islands, Pakistan, Papua New Guinea, Paraguay, Palau, Peru, Philippines, Qatar, Romania, Russian Federation, Rwanda, Sao Tome & Principe, Senegal, Sierra Leone, Solomon Islands, Somalia, South Africa, Sri Lanka, Sudan, Suriname, Swaziland, Taiwan, Tajikistan, Tanzania-UR, Thailand, Timor-Leste, Togo, Turkmenistan, Tuvalu, Uganda, Ukraine, Uzbekistan, Vanuatu, Vietnam, Yemen, Zambia, Zimbabwe Based on WHO Global TB Report 2009

6. IF you answer **NO** to all questions no further action is required. **Prior BCG 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.** TB skin tests ARE NOT ACCEPTED from other countries.		6b. CHEST X-RAY **Required within 6 months for past or current positive TB skin or blood test.** X-ray report ***MUST BE ATTACHED***	6c. TB TREATMENT **MEDICATION (with 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:

Signatures

I confirm that the information above is accurate.

Clinician Signature: **Date:**

Physical Examination Affirmation: **I have examined this patient on _____ and find no medical condition that would prohibit him/her from participating fully in all activities including physical education, trying out for competitive sports or military training and employment.**

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:**

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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
Anxiety/depression/mental illness	Endometriosis	Rheumatic Fever
Asthma	Gastrointestinal Problems	Seizures
Cancer	Hepatitis B or C Disease	Sickle Cell Anemia
Cardiac Condition/Heart Murmur	High Blood Pressure	Thyroid Disorder
Coagulation 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**

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

Medication	Food
Insect	Environmental
Seasonal	X-ray Contrast
Are any *life threatening?* ☐ **Yes** ☐ **No**	**Do you carry an Epi Pen?** ☐ **Yes** ☐ **No**

Prior Hospitalizations or Surgeries - Please list dates and reasons

Medications – Frequent or regular- 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**: Last 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 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