Connecticut State University Student Health Services Form Instructions

Important: Prior to submitting your information, please make a copy for your records

Connecticut General Statute and CCSU requires the following information for all matriculated students (full and part time). Please submit this form to Student Wellness Services-University Health Services no later than **July 15** for the Fall semester and **December 15** for the Spring semester. Failure to submit the required form will result in a health hold on your student account.

Proof of immunity to **Measles (Rubeola):** you must provide proof of one of the following*:*
- Two measles or two MMR immunizations (1st dose on or after your 1st birthday; second dose at least 28 days later); **OR**
- Lab results showing a positive measles titer (blood test) Please submit a copy of the lab report results with health form.

Proof of immunity to **Rubella:** you must provide proof of one of the following*:*
- Two rubella or two MMR immunizations (1st dose on or after your 1st birthday; second dose at least 28 days later); **OR**
- Lab results showing a positive rubella titer (blood test) Please submit a copy of the lab report results with health form.

Proof of immunity to **Mumps**: you must provide proof of one of the following*:*
- Two mumps or two MMR immunizations (1st dose on or after your 1st birthday; second dose at least 28 days later); **OR**
- Lab results showing a positive mumps titer (blood work) Please submit copy of the lab report results with health form.

Proof of immunity to **Varicella** (chicken pox): you must provide proof of one of the following*:*
- Two varicella immunizations (second dose at least 28 days after the first dose); **OR**
- Lab results showing a positive varicella titer (blood test) Please submit copy of the lab report results with health form.

Certification of confirmed cases of measles, mumps, rubella & varicella by a licensed health care provider may be submitted in lieu of the above. **(signed note from a medical provider).**

Proof of **Meningococcal A,C, W-135 or Y** vaccination (is required for all residential students prior to room assignment. **No student may move into campus housing without proof of this vaccine.** The vaccine must have been administered within five years before enrollment.

Hepatitis B: The American College Health Association, the Connecticut Public Health Department, and the Centers for Disease Control recommend students be immunized against **Hepatitis B** (*while not required it is strongly recommended*).

Tetanus: A booster shot is recommended every ten years.

IMMUNIZATION EXEMPTIONS

- **Students born prior to January 1, 1957 are exempt by age from the measles, mumps, and rubella requirement.**
- **Students born prior to January 1, 1980 are exempt by age from the varicella requirement.**

Please check your Central Pipeline account no sooner than 5-7 business days after submitting the required information. Your Central Pipeline account will indicate the MISSING information under the "Registration Status" Section. If you have a health hold and nothing is indicated as to what is missing, we have not received ANY information for you.

: Please make a copy for your record. Medical Records are not maintained or transferred with transcripts to other institutions by CCSU.

Please email documents to sws@ccsu.edu as a PDF attachment only.

Connecticut State University Student Health Services Form

FOR OFFICE USE ONLY

Semester Beginning School ☐Fall ☐ Spring of _____

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 #:** ☐☐☐☐☐☐☐☐☐

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:	**Incidence of Chicken Pox Disease** ***OR*** 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 (must include groups A, C, Y&W-135) If living on-campus, your most recent vaccination must be within 5 years of your 1st day of classes at the University. Please note: You will not be permitted to move in to campus housing without first providing the Student Health Service with this information.** **Date(s):1._____2._____ Brand of Vaccine: _____ ☐ I will not be living on-campus. 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,Anguilla,Argentina,Armenia,Azerbaijan,Bahrain,Bangladesh,Belarus,Belize,Benin,Bhutan,Bolivia,Bosnia&Herzegovina,Botswana,Brazil,Brunei,Darussalam,Bulgaria,BurkinaFaso,Burundi,Cambodia,Cameroon,CapeVerde,CentralAfricanRepublic,Chad,China,China:HongKongSpecialAdministrativeRegion,China:MacaoSpecialAdministrativeRegion,Colombia,Comoros,Congo,Côte d'Ivoire, Democratic People's Republic of Korea, Democratic Republic of the Congo,Djibouti,DominicanRepublic,Ecuador,ElSalvador,EquatorialGuinea,Eritrea,Estonia,Ethiopia,Fiji,FrenchPolynesia,Gabon,Gambia,Georgia,Ghana,Guam,Guatemala,Guinea,Guinea-Bissau,Guyana,Haiti,Honduras,India,Indonesia,Iraq,Iran,Japan,Kazakhstan,Kenya,Kiribati,Kuwait,Kyrgyzstan,LaoPeople'sDemocratic,Republic,Latvia,Lesotho,Liberia,Libyan,Arab,Jamahiriya,Lithuania,Madagascar,Malawi, Malaysia, Maldives, Mali, Marshall Islands,Mauritania,Mauritius,Mexico,Micronesia(FederatedStates),Mongolia,Morocco,Mozambique,Myanmar(Burma),Namibia,Nauru,Niue,Nepal,Netherlands,Antilles,NewCaledonia, Nicaragua,Niger,Nigeria,NorthernMarianaIslands,Pakistan,Palau,Panama,Papua,NewGuinea,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,SierraLeone,Singapore,SolomonIslands,Somalia,SouthAfrica,SouthSudan,SriLanka,Sudan,Suriname,Swaziland,Syrian,ArabRepublic,Tajikistan, Taiwan, Thailand, The former Yugoslav Republic of Macedonia,TimorLeste,Togo,Trinidad&Tobago,Turks&Caicos,Tunisia,Turkey,Turkmenistan,Tuvalu,Uganda,Ukraine,United Republic of Tanzania, Uruguay, Uzbekistan, Vanuatu, Venezuela(Bolivarian Republic),Viet Nam, Wallis and Futuna Islands, Yemen, Zambia ,Zimbabwe Based on WHO Global TB Report 2013

6. Prior BCG does not exempt patient from this requirement.

If you answer **NO** to all questions no further action is required.

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.

6a. TB BLOOD TEST ***OR*** ☐ Interferon-gamma release assay Date: Result: ☐ NEG ☐ POS	**6a. TB SKIN TEST** **Use 5TU Mantoux test only.** Date Planted: Date Read: Interpretation (**If no induration, mark 0**) ☐ NEG ☐ POS _____mm of induration	**6b. CHEST X-RAY** **Required within the past 12 months for a previous or current positive TB skin or blood test.** ***Copy of X-ray report MUST be attached. X-ray is not needed if asymptomatic AND completed full course of treatment for the positive TB test (latent TB).*** **Chest X-ray Date:** Result: ☐ Normal ☐ Abnormal ***(Attach copy of report)***	**6c. TB TREATMENT** **MEDICATION (with dose):** Frequency: Start & Completion Dates:

Other Vaccination History (Tetanus Booster within last 10 years and Hepatitis B series are recommended if not already completed)

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:**

Student 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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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/Substance Abuse	Dental Problems	Mononucleosis
Anemia	Diabetes	Mumps
Anxiety/Depression/Mental illness	Gastrointestinal Conditions/IBS	Rheumatic Fever
Asthma	Gynecological Conditions	Seizures
Cancer	Hepatitis B or C Disease	Sickle Cell Disease
Cardiac Condition/Heart Murmur	High Blood Pressure	Thyroid Disorder
Coagulation/Bleeding Disorder	HIV/AIDS	Tuberculosis
Concussion	Measles	Other – please explain

***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(s) or concern(s).

Current Height**: Current Weight**: Last Blood Pressure (if known)**:

*****not required***

Did you make a copy for your records?

Central Connecticut State University
University Health Services
1615 Stanley Street
New Britain, CT 06050