

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

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: <input type="checkbox"/> MALE <input type="checkbox"/> 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 ____/____/____ <small>CIRCLE ONE (UPDATED WITHIN PAST 10 YEARS)</small>		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 ____/____/____ <i>REQUIRED FOR ALL RESIDENCE HALL STUDENTS</i>		
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.

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		ALLERGIES: <input type="checkbox"/> No known drug allergies. List allergy and describe reaction that occurs
NAME	DOSAGE AND DOSING SCHEDULE	
_____	_____	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 ____/____/____

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, 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

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 SCREENING 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 _____

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.*