This Connecticut State University Student Health Services Form is mandatory and the only form that will be accepted as proof of vaccination. All information must be entered on the form. Entering or stamping, “See Attached,” may delay the processing of your form. We encourage attaching immunization records but dates must be entered on form. Please make this clear to your healthcare provider’s office when you drop off the form.

All students, including transfer and exchange students, and those changing from part-time to full-time status, are required to submit this form to University Health Service no later than **July 15** for the fall semester and **December 15** for the spring semester. Proof of adequate immunization against measles, mumps, rubella (MMR) and varicella (chicken pox) and completion of the Tuberculosis (TB) Risk Assessment are required. Failure to meet this requirement will affect your ability to register for classes or change your schedule. Part-time students are not required to have a clinician signature on the “Physical Examination Affirmation.” Page two is also optional for part-time students.

Guidelines for these state immunization requirements are below. If your form is submitted with any missing information, we will notify you requesting the necessary data. Make sure your correct contact information is updated on your WebCentral/Student Pipeline account. Messages regarding your health information requirements can also be seen on your Registration Status in your WebCentral account.

**PLEASE NOTE TRANSFER STUDENTS:** Your health information is not automatically transferred with your academic records from your prior university. You must submit a completed form with all required information as if you were a first time college student. Transfer students, like other incoming full time students, are required to provide proof of adequate immunization against measles, mumps, rubella (MMR) and varicella (chicken pox) along with completion of the Tuberculosis (TB) Risk Assessment.

University Health Services is here to assist you in the successful completion of your academic journey. If you encounter any difficulty in getting the required information or you have any questions please call us at (860) 832-1925. We are here to do everything we can to make your transition to life at CCSU as easy as possible. Please look our webpage, [www.ccsu.edu/health](http://www.ccsu.edu/health), for more information about the services we offer.

Congratulations on your admission to CCSU!

University Health Services  
Christopher Diamond, MD, Director  
Marisol Aponte, APRN, Associate Director
Connecticut General Statutes and CCSU require the following for all matriculated students

Proof of immunity to **Measles (Rubeola)**: you must provide proof of one of the following:
- Two measles or two MMR immunizations (one after your 1\textsuperscript{st} birthday and one at least one month later); OR
- Lab results showing a positive measles titer (blood test)

Proof of immunity to **Rubella**: you must provide proof of one of the following:
- Two rubella or two MMR immunizations (one after your 1\textsuperscript{st} birthday and one at least one month later); OR
- Lab results showing a positive rubella titer (blood test)

Proof of immunity to **Mumps**: you must provide proof of one of the following:
- Two mumps or two MMR immunizations (one after your 1\textsuperscript{st} birthday and one at least one month later); OR
- Lab results showing a positive mumps titer (blood work)

Proof of immunity to **Varicella** (chicken pox): you must provide proof of one of the following:
- Two varicella immunizations; OR
- Lab results showing a positive varicella titer (blood test),

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

Proof of **Meningococcal** vaccination (Menactra) **within five years of entering CCSU** is required for all residential students prior to room assignment. No student may move into campus housing until this requirement is met. Even if not living on-campus, we strongly recommend that all students be vaccinated against this disease. If it has been 5 years since your immunization, speak to your medical provider about getting a booster shot.

**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** (*this is not required*).

**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.
- Vaccination waivers for religious or medical reasons are acceptable and can be found at [www.ccsu.edu/health/forms](http://www.ccsu.edu/health/forms).

*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.*

- Online learners do not need to meet the immunization requirements.

Revised 06/19/14
Connecticut State University Student Health Services Form  

Date 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 #:  

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:  Measles Titer Date:  Result  Pos  Neg  Must be on or after 1st birthday.  

2  Mumps #1  or MMR  Date:  Mumps Titer Date:  Result  Pos  Neg  Must be at least 28 days after 1st immunization.  

3  Rubella #1  or MMR  Date:  Rubella Titer Date:  Result  Pos  Neg  Must be at least 28 days after 1st immunization.  

4  Varicella #1  or MMR  Date:  Varicella Titer Date:  Provider Initials:  Varicella is required only for students born on or after January 1, 1980  

5  Meningococcal (must include groups A,C,Y&W-135)  If living on-campus, your last vaccination must be within 5 years of your 1st day of school. 

Date(s):  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?  Yes  No  

D. Have you traveled or lived for more than one month in one or more of the countries listed below?  Yes  No  

6a. TB BLOOD TEST OR Interferon-gamma release assay  

Date:  Result:  NEG  POS  

6a. TB SKIN TEST  Use STU Mantoux test only.  

Date Planted:  Interpretation (If no induration, mark 0)  Result:  Pos  Neg  mm of induration  

6b. CHEST X-RAY Required within 1 year for past or current positive TB skin or blood test.  X-ray report MUST BE ATTACHED  

Date:  Frequency:  Start & Completion Dates:  

6c. TB TREATMENT MEDICATION (with dose):  

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:  

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:  

Afghanistan, Algeria, Angola, Argentina, Armenia, Azerbaijan, Bahrain, Bangladesh, Belarus, Belize, Benin, Bhutan, Bolivia, Bosnia and Herzegovina, Botswana, Brazil, Brunei, Darussalam, Bulgaria, Burkina Faso, Burundi, Cambodia, Cameroon, Cape Verde, Central African Republic, Chad, China, Hong Kong Special Administrative Region, Hong Kong, Macao Special Administrative Region, Colombia, Comoros, Congo, Côte d’Ivoire, Democratic People’s Republic of Korea, Democratic Republic of the Congo, Dominican Republic, Ecuador, El Salvador, Equatorial Guinea, Eritrea, Estonia, Ethiopia, Fiji, French Polynesia, Gabon, Gambia, Georgia, Ghana, Guinea, Guinea-Bissau, Guyana, Haiti, Honduras, India, Indonesia, Iran, Iraq, Japan, Kazakhstan, Kenya, Kiribati, Kuwait, Kyrgyzstan, Laos People’s Democratic Republic, Latvia, Lesotho, Liberia, Libyan Arab Jamahiriya, Lithuania, Madagascar, Malawi, Malaysia, Maldives, Mali, Marshall Islands, Mauritania, Mauritius, Mexico, Micronesia (Federated States), Mongolia, Morocco, Mozambique, Myanmar (Burma), Namibia, Nepal, Niger, Nigeria, Northern Mariana Islands, Pakistan, Palau, Panama, Papua New Guinea, 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, Sierra Leone, Singapore, Solomon Islands, Somalia, South Africa, South Sudan, Sri Lanka, Sudan, Suriname, Swaziland, Syrian Arab Republic, Tajikistan, Thailand, Timor-Leste, Togo, Trinidad and Tobago, Turkey, Turkmenistan, Tuvalu, Uganda, Ukraine, United Republic of Tanzania, Uruguay, Uzbekistan, Vanuatu, Venezuela (Bolivarian Republic), Vietnam, Wallis and Futuna Islands, Yemen, Zambia, Zimbabwe. 

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<tr>
<th>Permanent Home Information</th>
<th>Notify in Case of Emergency</th>
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<tbody>
<tr>
<td>Home Phone</td>
<td>Name</td>
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<tr>
<td>Cell/Work Phone</td>
<td>Relationship</td>
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<tr>
<td>Street Address</td>
<td>Home Phone</td>
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<td>Cell/Work Phone</td>
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<tr>
<th>Personal Physician/Healthcare Provider</th>
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</thead>
<tbody>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>Telephone #:</td>
</tr>
<tr>
<td>FAX #</td>
</tr>
</tbody>
</table>

**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 06265
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

Revised 06/23/2014