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

Connecticut State University Student Health Services Form Instructions

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 test 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 test 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 test 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 test 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 vaccination (Menactra) 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.
- Vaccination waivers for religious or medical reasons are acceptable and can be found at www.ccsu.edu/healthservice/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.

Please check your Central Pipeline account no sooner than 3 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. You may mail, fax, drop off (page 2 of form) or email to sws@ccsu.edu. Please only submit ONE copy of your form to avoid processing delays. Thank you.

Reminder: Prior to submitting your information, please make a copy for your records
PLEASE RETAIN A COPY OF THIS HEALTH FORM FOR YOUR RECORDS  BOTH SIDES/PAGES OF THIS FORM MUST BE SUBMITTED

State of Connecticut and Connecticut State Universities REQUIRE:

<table>
<thead>
<tr>
<th>Vaccine &amp; Date Given</th>
<th>Incidence of Disease</th>
<th>Titer Test Results (attach lab report)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles #1 Date</td>
<td></td>
<td>Measles Titer Date: Result Pos Neg</td>
<td>Must be on or after 1st birthday.</td>
</tr>
<tr>
<td>Mumps #1 Date</td>
<td></td>
<td>Mumps Titer Date: Result Pos Neg</td>
<td>Must be on or after 1st immunization.</td>
</tr>
<tr>
<td>Varicella #1 Date</td>
<td></td>
<td>Varicella Titer Date: Result Pos Neg</td>
<td></td>
</tr>
</tbody>
</table>

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

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, 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 STU Mantoux test only.

Date Planted: Interpretation (if no induration, mark 0)
Date Read: 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).

Results:

- 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)

<table>
<thead>
<tr>
<th>Hepatitis B #1 Date</th>
<th>Hepatitis B #2 Date</th>
<th>Hepatitis B #3 Date</th>
<th>Hepatitis Titer Date</th>
<th>Result: POS NEG</th>
</tr>
</thead>
</table>

Other Vaccination:

<table>
<thead>
<tr>
<th>Other Vaccination</th>
<th>Date:</th>
</tr>
</thead>
</table>

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: Date:

Signature of Parent/Guardian: Date:
Connecticut State University Student Health Services Form
Page 2

**PLEASE RETAIN A COPY OF THIS HEALTH FORM FOR YOUR RECORDS**  BOTH SIDES/PAGES OF THIS FORM MUST BE SUBMITTED

<table>
<thead>
<tr>
<th>Student Name</th>
<th>Home/Personal Email Address</th>
<th>Student Cell Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

**Permanent Home Information**

<table>
<thead>
<tr>
<th>Home Phone</th>
<th>Cell/Work Phone</th>
<th>Name</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Street Address</th>
<th>Home Phone</th>
<th>Cell/Work Phone</th>
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<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip</th>
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<tbody>
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</table>

**Personal Physician/Healthcare Provider**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Address:</th>
<th>Telephone #:</th>
<th>FAX #</th>
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</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**Personal Medical History- Please circle all below that apply to you.**

- 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 none apply
- Check here if you have no allergies

<table>
<thead>
<tr>
<th>Medication</th>
<th>Food</th>
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</thead>
<tbody>
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</table>

<table>
<thead>
<tr>
<th>Insect</th>
<th>Environmental</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Seasonal</th>
<th>X-ray Contrast</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

**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 sign the Consent for Treatment on Page 1?  
Did you make a copy for your records prior to submitting?

Please return by mail or fax to the appropriate Health Service listed below. You may also email to sws@ccsu.edu. Please send ONE copy only to avoid a delay.

Central Connecticut State University  
University Health Services  
1615 Stanley Street  
New Britain, CT 06050  
860/832-1925 Fax 860/832-2579

Eastern Connecticut State University  
University Health Services  
185 Birch Street  
Willimantic, CT 06266  
860/465-5263 Fax 860/465-4560

Southern Connecticut State University  
University Health Services  
501 Crescent Street  
New Haven, CT 06515  
203/392-6300 Fax 203/392-6301

Western Connecticut State University  
University Health Services  
181 White Street  
Danbury, CT 06810  
203/837-8594