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.

***VERY IMPORTANT: Please note that if you send this form to your doctor they will only complete sections 1-5 and 7a-7d if applicable. It is your responsibility as an incoming student to complete all other areas of the form prior to submission.

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);
- 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);
- 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);
- 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.**

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 moving into the residential halls.**

**Strongly Recommended**

**Meningitis B**: The Centers for Disease Control recommend students be immunized against **Meno B.** Please provide documentation of vaccine series in a separate document you’re your submission.

**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**

**Tetanus**: A booster shot is recommended every ten years – Mandatory for Student Athletes

**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 3 business days after submitting the required information. Your Central Pipeline account will indicate the MISSING information under the “Registration Status” Section.
Please make a copy for your record. Medical Records are not maintained or transferred with transcripts to other institutions by CCSU. You may fax to 860-832-2579, Email to sws@ccsu.edu, drop off or mail (Address page 2 of form). All documents sent by email must be sent as a PDF attachment only.

Connecticut State University Student Health Services Form

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 ____________________ Student ID #: ____________________

Date of Birth and Birthplace: ____________________ Sex/Gender: ____________________

<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 or MMR</td>
<td>Date:</td>
<td>Measles Titer Date:</td>
<td>Must be on or after 1st birthday.</td>
</tr>
<tr>
<td>Measles #2 or MMR</td>
<td>Date:</td>
<td>Mumps Titer Date:</td>
<td>Must be on or after 1st birthday.</td>
</tr>
<tr>
<td>Rubella #1 or MMR</td>
<td>Date:</td>
<td>Rubella Titer Date:</td>
<td>Must be on or after 1st birthday.</td>
</tr>
<tr>
<td>Varicella #1 or VAR</td>
<td>Date:</td>
<td>Varicella Titer Date:</td>
<td>Must be at least 28 days after 1st immunization</td>
</tr>
<tr>
<td>Varicella #2 or VAR</td>
<td>Date:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 Student Health Service with this information.

Date(s): ____________________ Brand of Vaccine: ____________________ I will not be living on-campus. I do not require this vaccine.

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

A. Have you ever had a positive tuberculin 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

7a. TB BLOOD TEST
OR Interferon-gamma release assay

Date: ____________________ Result: ☐ NEG ☐ POS

7b. TB SKIN TEST
Use STU Mantoux test only.

Date Planted: ____________________ Interpretation (If no induration, mark 0)
☐ NEG ☐ POS

Date Read: ____________________ mm of induration

7c. 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).

Date: ____________________ Result: ☐ Normal ☐ Abnormal

Attachment copy of report

7d. 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)
Last Tetanus Booster: Td [ ] or Tdap [ ]

Other Vaccination:

Other Vaccination:

Other Vaccination:

<table>
<thead>
<tr>
<th>Last Tetanus Booster: Td or Tdap</th>
<th>Other Vaccination</th>
<th>Other Vaccination</th>
<th>Other Vaccination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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: 

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.

Student Name

Home/Personal Email Address

Student Cell Phone

Permanent Home Information

Notify in Case of Emergency

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

<table>
<thead>
<tr>
<th>Street Address</th>
<th>Home Phone</th>
<th>Cell/Work Phone</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

Personal Physician/Healthcare Provider

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

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 [ ] 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)**:
Did you make a copy for your records?

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 06226

Southern Connecticut State University
University Health Services
501 Crescent Street
New Haven, CT 06515

Western Connecticut State University
University Health Services
181 White Street
Danbury, CT 06810
INFORMATION FROM STUDENT WELLNESS SERVICES
Central Pipeline Account Information

Please check the status of your required health information online:

1. Navigate to the CCSU home page at www.ccsu.edu. Point to CentralPipeline, then click on CentralPipeline for Students.

2. From the CentralPipeline home page, click on the WebCentral-Banner Web Tab and log in with your BlueNet account username and password.

3. From the Registration/Records tab, click on the Check Your Registration Status link. Current information regarding your required documentation is found here. Note: DO NOT CLICK ON “VIEW HOLDS”

4. Select Term (current semester)

If you are not complete you will see a message that says “Your medical records are not complete”. Missing information will be listed in red.

Once your documentation has been submitted to University Health Services, please allow 3-5 business days for processing.

Please keep a copy of your documentation, including fax confirmations for your record.

General information about University Health Services can be found at http://web.ccsu.edu/healthservices/index.asp

If you have any questions or concerns please contact us at sws@ccsu.edu

Thank you.