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 at least 5 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.

**Student Wellness Services – University Health Services**
860-832-1925 (Phone) 860-832-2579 (Fax) www.ccsu.edu/Healthservices
**Connecticut State University Student Health Services Form**

**State of Connecticut and Connecticut State Universities REQUIRE:**

<table>
<thead>
<tr>
<th>Vaccine &amp; Date Given</th>
<th>OR</th>
<th>Incidence of Disease</th>
<th>OR</th>
<th>Titer Test Results (attach lab report)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Measles #1</td>
<td>□️</td>
<td></td>
<td>□️</td>
<td>Measles Titer Date: Result □️ Pos □️ Neg</td>
<td>Must be on or after 1st birthday.</td>
</tr>
<tr>
<td>2 Mumps #1</td>
<td>□️</td>
<td></td>
<td>□️</td>
<td>Mumps Titer Date: Result □️ Pos □️ Neg</td>
<td>Must be on or after 1st birthday.</td>
</tr>
<tr>
<td>3 Rubella #1</td>
<td>□️</td>
<td></td>
<td>□️</td>
<td>Rubella Titer Date: Result □️ Pos □️ Neg</td>
<td>Must be on or after 1st birthday.</td>
</tr>
<tr>
<td>4 Varicella #1</td>
<td>□️</td>
<td></td>
<td>□️</td>
<td>Varicella Titer Date: Result □️ Pos □️ Neg</td>
<td>Varicella is required only for students born on or after January 1, 1980 #1 Must be on or after 1st birthday; #2 Must be on or after 28 days immunization.</td>
</tr>
</tbody>
</table>

**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 answers, “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

**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>

**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 STU Mantoux test only.

- Date Planted: □️ 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).

- Date: _Result: □️ Normal □️ Abnormal (Attach copy of report)_

**6c. TB TREATMENT MEDICATION (with dose):**

Frequency: _Start & Completion Dates_

**Other Vaccination History**

<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>

**Clinician Signature:** _Date:_

I confirm that the information above is accurate.

**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.

**Signature of Student:** _Date:_

**Signature of Parent/Guardian:** _Date:_

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.
### Permanent Home Information

<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>
<th>Street Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Notify in Case of Emergency

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

**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

- Check here if you have no allergies

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

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

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

<table>
<thead>
<tr>
<th>Current Height**</th>
<th>Current Weight**</th>
<th>Last Blood Pressure (if known)**</th>
</tr>
</thead>
</table>

**not required**

### Student - Did you sign the Consent for Treatment on Page 1?

- Please return by mail or fax to the appropriate Health Service listed below.

<table>
<thead>
<tr>
<th>Central Connecticut State University</th>
<th>Eastern Connecticut State University</th>
<th>Southern Connecticut State University</th>
<th>Western Connecticut State University</th>
</tr>
</thead>
<tbody>
<tr>
<td>University Health Services</td>
<td>University Health Services</td>
<td>University Health Services</td>
<td>University Health Services</td>
</tr>
<tr>
<td>1615 Stanley Street</td>
<td>185 Birch Street</td>
<td>501 Crescent Street</td>
<td>181 White Street</td>
</tr>
<tr>
<td>New Britain, CT 06050</td>
<td>Willimantic, CT 06226</td>
<td>New Haven, CT 06515</td>
<td>Danbury, CT 06810</td>
</tr>
</tbody>
</table>