Health Information Requirements: New, Matriculated Part-Time Students
(Including transfer and exchange students)
ACADEMIC YEAR 2011-2012

All part-time, matriculated students are required to complete page one of the Connecticut State University Student Health Services Form (attached below). Please note University Health Services will not accept copies of immunization forms. This Connecticut State University Student Health Services Form is mandatory and the only form that will be accepted as proof of vaccination. Please make this clear to your healthcare provider’s office when you drop off the form.

The following are required:

- Proof of adequate immunization against measles, mumps, rubella (MMR) and varicella (chicken pox). Guidelines for these state immunization requirements are below.

- Completed tuberculosis risk assessment questionnaire and testing if indicated.

- Your medical provider’s signature where indicated. No pre-admission physical exam is required.

Please enter the dates of immunizations directly to the health form. Attaching additional pages from your healthcare provider is acceptable but you must also write the dates onto the form. Not doing so is the most common cause of students missing required information which can result in delays in registering for classes.

Page two is optional for part-time students. This information will allow us to better care for you if you are ever seen in health services for a sick visit.

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, 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
Immunization Requirements and Exemptions

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 1st 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 1st 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 1st 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) is required for all residential students prior to room assignment. No student may move into campus housing without proof of this vaccine. It is strongly recommended 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 12/22/10*
Connecticut State University Student Health Services Form

Date Beginning School: Fall □ Spring □

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

Date of Birth and Birthplace:

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

<table>
<thead>
<tr>
<th>Vaccine &amp; Date Given OR Incidence of Disease</th>
<th>Titer Test Results (attach lab report)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Measles #1 or MMR Date:</td>
<td>Measles Titer Date:</td>
<td><strong>Must be on or after 1st birthday.</strong></td>
</tr>
<tr>
<td>2 Mumps #1 or MMR Date:</td>
<td>Mumps Titer Date:</td>
<td><strong>Must be on or after 1st birthday.</strong></td>
</tr>
<tr>
<td>3 Rubella #1 or MMR Date:</td>
<td>Rubella Titer Date:</td>
<td><strong>Must be on or after 1st birthday.</strong></td>
</tr>
<tr>
<td>4 Varicella #1 or MMR Date:</td>
<td>Varicella Titer Date:</td>
<td><strong>Must be at least 28 days after 1st immunization.</strong></td>
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<tr>
<td>5 Meningococcal Vaccine Type or Brand:</td>
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</tbody>
</table>

**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

B. To the best of your knowledge have you ever had close contact with anyone who was sick with tuberculosis (TB)?

C. Were you born in one of the countries listed below? If yes circle country

D. Have you traveled or lived for more than one month in one or more of the countries listed below? If yes circle country

6. If you answer NO to all questions no further action is required. Prior BCG does not exempt patient from this requirement.

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

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

**TB skin tests ARE NOT ACCEPTED from other countries**

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<thead>
<tr>
<th>Date Planted:</th>
<th>Interpretation (if no induration, mark 0)</th>
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<tbody>
<tr>
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<td>NEG</td>
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6b. CHEST X-RAY Required within 6 months for past or current positive TB skin or blood test. X-ray report MUST BE ATTACHED

<table>
<thead>
<tr>
<th>Chest X-ray Date:</th>
<th>Frequency: Start &amp; Completion Dates:</th>
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<tbody>
<tr>
<td>Normal</td>
<td>Abnormal</td>
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<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 Result:</th>
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<td>POS</td>
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Last Tetanus Booster: Td | or Tdap | Other Vaccination: | Other Vaccination: |

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 all 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:

Continue to Page 2 →
### Permanent Home Information

<table>
<thead>
<tr>
<th>Home Phone</th>
<th>Cell/Work Phone</th>
<th>Name</th>
<th>Relationship</th>
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<tr>
<th>Street Address</th>
<th>Home Phone</th>
<th>Cell/Work Phone</th>
<th>Name</th>
<th>Relationship</th>
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<tr>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Street Address</th>
<th>Home Phone</th>
<th>Cell/Work Phone</th>
<th>Name</th>
<th>Relationship</th>
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### Personal Physician/Healthcare Provider

<table>
<thead>
<tr>
<th>Name:</th>
<th>Address:</th>
<th>Telephone #:</th>
<th>FAX #:</th>
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### Personal Medical History- Please circle all below that apply to you

- Alcohol/drug Abuse
- Anxiety/depression/mental illness
- Asthma
- Cancer
- Cardiac Condition/Heart Murmur
- Coagulation Disorder
- Concussion
- Dental Problems
- Diabetes
- Endometriosis
- Gastrointestinal Problems
- Hepatitis B or C Disease
- High Blood Pressure
- HIV/AIDS
- Measles
- Mononucleosis
- Mumps
- Rheumatic Fever
- Seizures
- Sickle Cell Anemia
- Thyroid Disorder
- Tuberculosis
- Other please explain

### Allergies: Drugs & Other Severe Adverse Reactions - Please complete all that apply and explain reaction

- Medication
- Food
- Insect
- Environmental
- Seasonal
- X-ray Contrast

**Are any life threatening?**

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<thead>
<tr>
<th>Yes</th>
<th>No</th>
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**Do you carry an Epi Pen?**

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<th>Yes</th>
<th>No</th>
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</table>

### 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 06266
- 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 01/14/11