Connecticut State University Student Health Services Form

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.

REQUIRED FOR ALL INCOMING FULL TIME STUDENTS
(Including transfer and exchange students, and those changing from part-time to full-time status)

All full time students 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.

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, 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 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.
Connecticut State University Student Health Services Form

Please retain a copy of this health form for your records. Both sides/pages of this form must be submitted.

Date: Beginning School □ Fall □ Spring of ____________

FOR OFFICE USE ONLY
□ Complete □ Missing:

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

<table>
<thead>
<tr>
<th>Vaccine &amp; Date Given</th>
<th>OR Incidence of Disease</th>
<th>OR 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>Measles Titer Results (attach lab report)</td>
<td>Must be on or after 1st birthday.</td>
</tr>
<tr>
<td>2 Mumps #1 (or MMR) Date:</td>
<td>Mumps Titer Date:</td>
<td>Mumps Titer Results (attach lab report)</td>
<td>Must be on or after 1st birthday.</td>
</tr>
<tr>
<td>3 Rubella #1 (or MMR) Date:</td>
<td>Rubella Titer Date:</td>
<td>Rubella Titer Results (attach lab report)</td>
<td>Must be on or after 1st birthday.</td>
</tr>
<tr>
<td>4 Varicella #1 (or MMR) Date:</td>
<td>Varicella Titer Date:</td>
<td>Varicella Titer Results (attach lab report)</td>
<td>Must be on or after 1st birthday.</td>
</tr>
<tr>
<td>5 Meningococcal Vaccine Type or Brand: Date:</td>
<td>*Required only if living in university owned housing.</td>
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</tbody>
</table>

6. 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.

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

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

D. If yes to questions A through D, Answer “Yes” to the following questions:

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)
□ NEG □ POS

Date Read: ___________________________

28 mm of induration

6b. CHEST X-RAY

Required within 6 months of past or current positive TB skin or blood test. X-ray report MUST BE ATTACHED

Frequency: ___________________________

Start & Completion Dates: ___________________________

6c. TB TREATMENT MEDICATION (with dose):

Prior BCG does not exempt patient from this requirement.

Other Vaccination History (Tetanus Booster within last 10 years and Hepatitis B series are recommended)

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>Hepatitis B #1</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B #2</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B #3</td>
<td></td>
</tr>
<tr>
<td>Tetanus Booster</td>
<td></td>
</tr>
</tbody>
</table>

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: ___________________________ Date: ___________________________

Signature of Parent/Guardian: ___________________________ Date: ___________________________

Continue to Page 2 →
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>
</table>

### 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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</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</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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</table>

### Notify in Case of Emergency

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

### 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

- [ ] Check here if you have no allergies

<table>
<thead>
<tr>
<th>Medication</th>
<th>Food</th>
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<thead>
<tr>
<th>Insect</th>
<th>Environmental</th>
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<table>
<thead>
<tr>
<th>Seasonal</th>
<th>X-ray Contrast</th>
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</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 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 06226  
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  
203/837-8583 Fax 203/837-8583

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