Health Requirements for Full-Time International students

Below you will find the *Connecticut State University (CSU) Confidential Health Form.* All sections of the form must be completed and signed where indicated. Failure to do so will affect your ability to register for or change classes. 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.

1) **Required Immunizations (full information on the next page):** Connecticut law and CCSU require all full-time students to provide proof of *adequate* immunization against:

a. **measles, mumps, rubella (MMR); and**

b. **varicella (chicken pox);**

Students living in the residence halls must be vaccinated against **meningococcal disease.** The United States requires this vaccine with subtypes A, C, Y, W 135 in the vaccine, which may not be available in your country. You must be vaccinated against all four types prior to moving in to the halls. For more information on meningitis prevention, please go to the Meningococcal vaccination update under "**Important Medical Updates"** tab on our home page www.ccsu.edu/health. We also recommend students be fully immunized against Hepatitis B. and have a tetanus booster shot within the last ten years.

2) T**uberculosis Screening:** CCSU also requires completion of the **Tuberculosis (TB) Risk Assessment**. Please review the Tuberculosis (TB) Risk Assessment carefully as you may need to have a tuberculosis screening test (either a skin test or a blood test). If so, **this test must be administered by an American medical facility within 6 months of attending CCSU.**

3) **Medical Provider Signature: The form must be signed by a medical provider.**

University Health Services offers tuberculosis testing, MMR, varicella, and meningococcal vaccination. Additional immunizations are offered in our office. There are fees for the test and the vaccinations that will be charged to your university account.

Please provide all required information to University Health Services as soon as possible but no later than than two weeks prior to arriving on campus. Additional medical information may be needed, and we will notify you by e-mail to enable you to obtain this medical information while you are still in your country.

You may not be able to register for classes, make schedule changes or move into a residence hall if you do not meet these health requirements or complete the form satisfactorily. We are here to make sure this does not occur. Please call us at 860-832-1925 with any questions.

HEALTH INSURANCE CONSIDERATIONS

All Central Connecticut State University students are required to maintain a health insurance policy that meets or exceeds the coverage provided by the Aetna Student Health Insurance policy offered by the University. While you may waive this policy by providing proof of alternate health insurance coverage, please be aware that many healthcare providers (physician and medical facilities) in the local area surrounding the University may not accept your form of alternate health insurance coverage, leaving you personally responsible for your medical bills or refusing to see you (even if you can afford to pay at the time of the visit). Therefore, the Center for International Education and University Health Services strongly encourage all international students to purchase the Aetna Student Health Insurance policy offered through the University. For more information about health insurance please **click here**.

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 college 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

Revised 4/8/11:6/8/12

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 (against types A, C, Y, and W135; e.g. 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.
  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 01/19/11

Connecticut State University Student Health Services Form

Date Beginning School ☐Fall ☐ Spring of ___________

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

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

	Vaccine & Date Given ***OR***	Incidence of Disease ***OR***	Titer Test Results (attach lab report)	Requirements
1	Measles #1 ☐ or MMR ☐ Date	Date:	Measles Titer Date :	***Must be*** on or after 1st birthday.
	Measles #2 ☐ or MMR ☐ Date:		Result ☐Pos ☐ Neg	***Must be*** at least 28 days after 1st immunization.
2	Mumps #1 ☐ or MMR ☐ Date:	Date	Mumps Titer Date:	***Must be*** on or after 1st birthday.
	Mumps #2 ☐ or MMR ☐ Date:		Result ☐Pos ☐ Neg	***Must be*** at least 28 days after 1st immunization.
3	Rubella #1 ☐ or MMR ☐ Date:	Date	Rubella Titer Date:	***Must be*** on or after 1st birthday.
	Rubella #2 ☐ or MMR ☐ Date:		Result ☐Pos ☐ Neg	***Must be*** at least 28 days after 1st immunization.
4	Varicella #1 ☐ ***OR*** Date: Varicella #2 ☐ Date:	Incidence of ***OR*** Disease Chicken Pox Date: Provider Initials:	Varicella Titer Date: Result ☐Pos ☐ Neg	**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**
5	**Meningococcal** ☐ **Vaccine Type or Brand:** **Date :**		***Required only if living in university owned housing.** ☐ **I will not be living in University owned housing. I do not require this vaccine.**	

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

Question	
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**	☐ 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

Afghanistan, Algeria, Angola, Armenia, Azerbaijan, Bangladesh, Belarus, Benin, Bhutan, Bolivia, Bosnia & Herzegovina, Botswana, Brunei Darussalam, Burkina Faso, Burundi, Cambodia, Cameroon, Cape Verde, Central African Republic, Chad, China,China-Hong Kong, China-Macao, Congo, Congo DR, Cote d'Ivoire, Djibouti, Dominican Rep., Ecuador, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Georgia, Ghana, Guatemala, Guinea, Guinea-Bissau, Guyana, Haiti, Honduras, India, Indonesia, Iraq, Kazakhstan, Kenya, Kiribati, Korea-DPR, Korea-Rep, Kyrgyzstan, Lao PDR, Latvia, Lesotho, Liberia, Lithuania, TFYR, Madagascar, Malawi, Malaysia, Mali, Marshall Islands, Mauritania, Micronesia, Moldova-Rep, Mongolia, Morocco, Mozambique, Myanmar, Namibia, Nepal, Niger, Nigeria, Northern Mariana Islands, Pakistan, Papua New Guinea, Paraguay, Palau, Peru, Philippines, Qatar, Romania, Russian Federation, Rwanda, Sao Tome & Principe, Senegal, Sierra Leone, Solomon Islands, Somalia, South Africa, Sri Lanka, Sudan, Suriname, Swaziland, Taiwan, Tajikistan, Tanzania-UR, Thailand, Timor-Leste, Togo, Turkmenistan, Tuvalu, Uganda, Ukraine, Uzbekistan, Vanuatu, Vietnam, Yemen, Zambia, Zimbabwe   Based on WHO Global TB Report 2009

6. IF you answer NO to all questions no further action is required.   **Prior BCG does not exempt patient from this requirement.**
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 and x-ray ***within 6 months prior to the start of classes.*** (After February for Fall Semester and after July for Spring Semester.)

6a. TB BLOOD TEST OR	**6a. TB SKIN TEST** **Use 5TU Mantoux test only.** **TB skin tests ARE NOT ACCEPTED from other countries.**		**6b. CHEST X-RAY** **Required within 6 months for past or current positive TB skin or blood test.** ***X-ray report MUST BE ATTACHED***	**6c. TB TREATMENT** **MEDICATION (with dose):**
☐ Interferon-gamma release assay Date: Result: ☐ NEG ☐ POS	**Date Planted:** **Date Read:**	Interpretation (**If no induration, mark 0**) ☐ NEG ☐ POS _______mm of induration	**Chest X-ray Date:** ☐ Normal ☐ Abnormal	Frequency: Start & Completion Dates:

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

Hepatitis B #1 Date	Hepatitis B #2 Date	Hepatitis B #3 Date	Hepatitis Titer Date	Result: ☐ POS ☐ NEG
Last Tetanus Booster: Td ☐ or Tdap ☐ Date:	Other Vaccination:	Other Vaccination:	Other Vaccination:	

Signatures

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   **Signature of Parent/Guardian**   **Date:**

Continue to Page 2 →

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

Student Name	Home/Personal Email Address	Student Cell Phone

Permanent Home Information			Notify in Case of Emergency		
Home Phone	Cell/Work Phone		Name	Relationship	
Street Address			Home Phone	Cell/Work Phone	
City	State	Zip	Street Address		
			City	State	Zip

Personal Physician/Healthcare Provider	
Name:	Address:
	Telephone #: FAX #

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

☐ **Check here if none apply**

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

***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 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
181White Street
Danbury, CT 06810
203/837-8594 Fax 203/837-8583