Connecticut State University Student Health Services Form Instructions

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 August 15th (extended deadline) for the Fall semester and December 15th 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. You may attach vaccination record from your physician office to the form as an alternative to your physician signing the form.

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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 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); OR
- 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); OR
- 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.

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**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.

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**Strongly Recommended**

**Meningitis B:** The Centers for Disease Control recommend students be immunized against Meningitis B.

**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

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*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.*

*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.*

**Important: Prior to submitting your information, please make a copy for your records**
Connecticut State University Student Health Services Form

**Semester Beginning School [ ] Fall [ ] Spring of**

**PLEASE RETAIN A COPY OF THIS HEALTH FORM FOR YOUR RECORDS**

**BOTH SIDES/PAGES OF THIS FORM MUST BE SUBMITTED**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
</tr>
</thead>
</table>

**Date of Birth and Birthplace:**

<table>
<thead>
<tr>
<th>Sex/Gender:</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Date:</th>
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</table>

**Student ID #:**

<table>
<thead>
<tr>
<th>Number:</th>
</tr>
</thead>
</table>

### TWO doses for each Measles, Mumps, Rubella & Varicella

<table>
<thead>
<tr>
<th>Vaccine &amp; Date Given</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><strong>Measles #1</strong></td>
<td>Date:</td>
<td>Measles Titer Date:</td>
<td>Result:</td>
<td>Pos</td>
</tr>
<tr>
<td><strong>Mumps #1</strong></td>
<td>Date:</td>
<td>Mumps Titer Date:</td>
<td>Result:</td>
<td>Pos</td>
</tr>
<tr>
<td><strong>Rubella #1</strong></td>
<td>Date:</td>
<td>Rubella Titer Date:</td>
<td>Result:</td>
<td>Pos</td>
</tr>
<tr>
<td><strong>Varicella #1</strong></td>
<td>Date:</td>
<td>Varicella Titer Date:</td>
<td>Result:</td>
<td>Pos</td>
</tr>
</tbody>
</table>

**Varicella is required only for students born on or after January 1, 1980.**

### One dose of Meningitis

**Complete TB Risk and/or Test or Treatment**

**Requirements**

- Must be on or after 1st birthday.
- Must be at least 28 days after 1st immunization.
- Must be on or after 1st birthday.
- Must be on or after 1st birthday.
- Must be at least 28 days after 1st immunization.
- Must be on or after 1st birthday.

### Meningoococal

(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 into campus housing without first providing Student Health Services with this information.

**Date(s):**

<table>
<thead>
<tr>
<th>Brand of Vaccine:</th>
</tr>
</thead>
</table>

**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 tuberculosis skin or blood test in the past? **If you answer, "Yes," Section 7b., "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

- [ ] Afghanistan
- [ ] Algeria
- [ ] Angola
- [ ] Argentina
- [ ] Armenia
- [ ] Azerbaijan
- [ ] Bangladesh
- [ ] Belarus
- [ ] Benin
- [ ] Bhutan
- [ ] Bolivia
- [ ] Botswana
- [ ] Brazil
- [ ] Brunei Darussalam
- [ ] Bulgaria
- [ ] Burkina Faso
- [ ] Burundi
- [ ] Cambodia
- [ ] Cameroon
- [ ] Canada
- [ ] Central African Republic
- [ ] Chad
- [ ] China
- [ ] Colombia
- [ ] Comoros
- [ ] Cote d’Ivoire
- [ ] Democratic People’s Republic of Korea
- [ ] Democratic Republic of the Congo
- [ ] Djibouti
- [ ] Dominica
- [ ]DR Congo
- [ ] Ecuador
- [ ] El Salvador
- [ ] Equatorial Guinea
- [ ] Eritrea
- [ ] Estonia
- [ ] Ethiopia
- [ ] Falkland Islands
- [ ] Fiji
- [ ] Finland
- [ ] France
- [ ] French Guiana
- [ ] Gabon
- [ ] Georgia
- [ ] Germany
- [ ] Ghana
- [ ] Greece
- [ ] Grenada
- [ ] Guatemala
- [ ] Guinea
- [ ] Guinea-Bissau
- [ ] Guyana
- [ ] Haiti
- [ ] Honduras
- [ ] Hong Kong
- [ ] Hungary
- [ ] Iceland
- [ ] India
- [ ] Indonesia
- [ ] Iran
- [ ] Iraq
- [ ] Ireland
- [ ] Israel
- [ ] Italy
- [ ] Japan
- [ ] Jordan
- [ ] Kazakhstan
- [ ] Kenya
- [ ] Kiribati
- [ ] Korea, Democratic People’s Republic of
- [ ] Korea, Republic of
- [ ] Kuwait
- [ ] Kyrgyzstan
- [ ] Лаосская Народная Республика
- [ ] Lebanon
- [ ] Lesotho
- [ ] Liberia
- [ ] Libya
- [ ] North Korea
- [ ] Norway
- [ ] Oman
- [ ] Pakistan
- [ ] Palau
- [ ] Panama
- [ ] Papua New Guinea
- [ ] Paraguay
- [ ] Peru
- [ ] Philippines
- [ ] Poland
- [ ] Portugal
- [ ] Pakistan
- [ ] Republik Korea, Republic of
- [ ] Romania
- [ ] Russian Federation
- [ ] Rwanda
- [ ] Saint Vincent and the Grenadines
- [ ] Samoa
- [ ] San Marino
- [ ] Sao Tome and Principe
- [ ] Senegal
- [ ] Serbia
- [ ] Seychelles
- [ ] Sierra Leone
- [ ] Singapore
- [ ] Solomon Islands
- [ ] Somalia
- [ ] South Africa
- [ ] South Sudan
- [ ] Sri Lanka
- [ ] Sudan
- [ ] Suriname
- [ ] Swaziland
- [ ] Syrian Arab Republic
- [ ] Tajikistan
- [ ] Thailand
- [ ] Timor-Leste
- [ ] Togo
- [ ] Tonga
- [ ] Trinidad and Tobago
- [ ] Turkey
- [ ] Turkmenistan
- [ ] Tuvalu
- [ ] Uganda
- [ ] Uruguay
- [ ] Uzbekistan
- [ ] Vanuatu
- [ ] Venezuela
- [ ]Viet Nam
- [ ] Wallis and Futuna Islands
- [ ] Yemen
- [ ] Zambia
- [ ] Zimbabwe

**If yes circle country**

If you answered 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.

### TB BLOOD TEST

- [ ] Interferon-gamma release assay

<table>
<thead>
<tr>
<th>Date:</th>
</tr>
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</table>

Result: [ ] NEG [ ] POS

<table>
<thead>
<tr>
<th>Date Planted:</th>
</tr>
</thead>
</table>

Interpretation (If no induration, mark 0)

<table>
<thead>
<tr>
<th>Date Read:</th>
</tr>
</thead>
</table>

mm of induration

### TB SKIN TEST

- [ ] Use 5TU Mantoux test only.

<table>
<thead>
<tr>
<th>Date:</th>
</tr>
</thead>
</table>

### TB 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).**

<table>
<thead>
<tr>
<th>Chest X-Ray Date:</th>
</tr>
</thead>
</table>

Result: [ ] Normal [ ] Abnormal

(Attach copy of report)

### TB TREATMENT MEDICATION (with dose):

<table>
<thead>
<tr>
<th>Frequency:</th>
</tr>
</thead>
</table>

Start & Completion Dates:

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

<table>
<thead>
<tr>
<th>Hepatitis B #2</th>
<th>Date:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Hepatitis B #3</th>
<th>Date:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Hepatitis Titer</th>
<th>Date:</th>
</tr>
</thead>
</table>

Result: [ ] POS [ ] NEG

### 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:**
### Permanent Home Information

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

### Personal Physician/Healthcare Provider

| Name: | Address: | Telephone #: | FAX #: |

### 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 - 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)**:

**not required**

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CCSU Health Services  
1615 Stanley Street  
New Britain, CT 06050  
860/832-1925 Fax 860/832-2579  
sws@ccsu.edu