Connecticut State University Student Health Services Form Instructions

**Important: Prior to submitting your information, please make a copy for your records**

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 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.

**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 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 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.

**Please check your Central Pipeline account no sooner than 5-7 business 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.**

**Please make a copy for your record. Medical Records are not maintained or transferred with transcripts to other institutions by CCSU.**

**Please email documents to sws@ccsu.edu as a PDF attachment only.**
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>Incidence of Disease</th>
<th>Titer Test Results (attach lab report)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Measles #1</strong></td>
<td>Date:</td>
<td>Measles Titer Date:</td>
<td>Must be on or after 1st birthday.</td>
</tr>
<tr>
<td>OR</td>
<td></td>
<td>Result:</td>
<td>Must be at least 28 days after 1st immunization.</td>
</tr>
<tr>
<td><strong>2. Mumps #1</strong></td>
<td>Date:</td>
<td>Mumps Titer Date:</td>
<td>Must be on or after 1st birthday.</td>
</tr>
<tr>
<td>OR</td>
<td></td>
<td>Result:</td>
<td>Must be at least 28 days after 1st immunization.</td>
</tr>
<tr>
<td><strong>3. Rubella #1</strong></td>
<td>Date:</td>
<td>Rubella Titer Date:</td>
<td>Must be on or after 1st birthday.</td>
</tr>
<tr>
<td>OR</td>
<td></td>
<td>Result:</td>
<td>Must be at least 28 days after 1st immunization.</td>
</tr>
<tr>
<td><strong>4. Varicella #1</strong></td>
<td>Date:</td>
<td>Varicella Titer Date:</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 at least 28 days after 1st immunization.</td>
</tr>
<tr>
<td>OR</td>
<td></td>
<td>Provider Initials:</td>
<td></td>
</tr>
</tbody>
</table>

Meningococcal (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 in to campus housing without first providing the Student Health Service with this information.

Date[s]: 1. _______ 2. _______ Brand of Vaccine: ______________________

I will not be living on-campus. I do not require this vaccine.

### TUBERCULOSIS (TB) RISK QUESTIONNAIRE - A thorough 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.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

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

| Afghanistan, Algeria, Angola, Argentina, Armenia, Azerbaijan, Bahrain, Bangladesh, Belarus, Belize, Benin, Bhutan, Bolivia, Bosnia and Herzegovina, Botswana, Brazil, Brunei, Darussalam, Bulgaria, Burkina Faso, Burundi, Cambodia, Cameroon, Côte d’Ivoire, Democratic People’s Republic of Korea, Democratic Republic of the Congo, Djibouti, Dominica, Republic of Ecuador, El Salvador, Equatorial Guinea, Eritrea, Ethiopia, Fiji, French Polynesia, Gabon, Gambia, Georgia, Ghana, Guam, Guatemala, Guinea-Bissau, Guyana, Haiti, Honduras, India, Indonesia, Iran, Iraq, Ireland, Israel, Japan, Kazakhstan, Kenya, Kiribati, Kuwait, Kyrgyzstan, Lao People’s Democratic Republic, Latvia, Lesotho, Liberia, Libyan Arab Jamahiriya, Lithuania, Madagascar, Malawi, Malaysia, Maldives, Mali, Marshall Islands, Mauritania, Mauritius, Mexico, Micronesia (Federated States of), Mongolia, Morocco, Mozambique, Myanmar (Burma), Namibia, Nauru, Nepal, Netherlands Antilles, New Caledonia, Nicaragua, Niger, Nigeria, Northern Mariana Islands, Pakistan, Palau, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Poland, Portugal, Qatar, Republic of Korea, Republic of Moldova, Romania, Russian Federation, Rwanda, Saint Vincent and the Grenadines, Sao Tome and Principe, Senegal, Serbia, Seychelles, Sierra Leone, Singapore, Solomon Islands, Somalia, South Africa, South Sudan, Sri Lanka, Sudan, Suriname, Swaziland, Syria, Tajikistan, Taiwan, Thailand, The Former Yugoslav Republic of Macedonia, Timor Leste, Tonga, Trinidad and Tobago, Turks and Caicos Islands, Turkey, Turkmenistan, Tuvalu, Uganda, Ukraine, United Republic of Tanzania, Uruguay, Uzbekistan, Vanuatu, Venezuela, Bolivarian Republic of, Viet Nam, Wallis and Futuna Islands, Yemen, Zambia, Zimbabwe | | |

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

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

### 6a. TB BLOOD TEST

**OR**

Interferon-gamma release assay

Date: 

Result: | NEG | POS |
|-------|-----|----|

**6a. TB SKIN TEST**

Use 5TU Mantoux test only.

**Date Planted:** [ ] NEG [ ] POS

**Date Read:** [ ] NEG [ ] POS

**Interpretation:** (If no induration, mark O)

--- 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).**

**Chest X-ray Date:**

Result: [ ] Normal [ ] Abnormal

**Frequency:**

**Start & Completion Dates:**

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

#### 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>
<th>Hepatitis B #2</th>
<th>Date</th>
<th>Hepatitis B #3</th>
<th>Date</th>
<th>Hepatitis Titer</th>
<th>Date</th>
<th>Result:</th>
<th>POS</th>
<th>NEG</th>
</tr>
</thead>
</table>

Last Tetanus Booster: Td [ ] or Tdap [ ]

**Other Vaccination:**

**Other Vaccination:**

### 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:**
### 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>Permanent Home Information</th>
<th>Notify in Case of Emergency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home Phone</strong></td>
<td><strong>Name</strong></td>
</tr>
<tr>
<td><strong>Cell/Work Phone</strong></td>
<td><strong>Relationship</strong></td>
</tr>
<tr>
<td><strong>Street Address</strong></td>
<td><strong>Home Phone</strong></td>
</tr>
<tr>
<td><strong>City</strong></td>
<td><strong>Cell/Work Phone</strong></td>
</tr>
<tr>
<td><strong>State</strong></td>
<td><strong>Street Address</strong></td>
</tr>
<tr>
<td><strong>Zip</strong></td>
<td><strong>City</strong></td>
</tr>
<tr>
<td><strong>State</strong></td>
<td><strong>Zip</strong></td>
</tr>
</tbody>
</table>

### Personal Physician/Healthcare Provider

<table>
<thead>
<tr>
<th>Name:</th>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Telephone #:</strong></td>
<td><strong>FAX #</strong></td>
</tr>
</tbody>
</table>

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

- Check here if none apply
- 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

Did you make a copy for your records?
INFORMATION FROM STUDENT WELLNESS SERVICES
Central Pipeline Account Information

Please check the status of your required health information online:

1. Navigate to the CCSU home page at www.ccsu.edu. Point to CentralPipeline, then click on CentralPipeline for Students.

2. From the CentralPipeline home page, click on the WebCentral-Banner Web Tab and log in with your BlueNet account username and password.

3. From the Registration/Records tab, click on the Check Your Registration Status link. Current information regarding your required documentation is found here. Note: DO NOT CLICK ON “VIEW HOLDS”

4. Select Term (current semester)

If you are not complete you will see a message that says
“Your medical records are not complete”.
Missing information will be listed in red.

Once your documentation has been submitted to University Health Services, please allow 5-7 business days for processing.

Please keep a copy of your documentation, including fax confirmations for your record.

General information about University Health Services can be found at http://web.ccsu.edu/healthservices/index.asp

If you have any questions or concerns please contact us at sws@ccsu.edu

Thank you.