**Student Wellness Center, Health Services**

**Connecticut State University Student Health Services Form**

Please submit your health form by uploading to the Medicat Portal. The patient portal can be accessed by visiting the following link [**https://ccsu.medicatconnect.com/**](https://ccsu.medicatconnect.com/)or scanning the **QR code** below.

Once your documentation has been submitted to University Health Services, please allow three to five business days for processing.



**For further information, please visit https://web.ccsu.edu/healthservices/.**

**Connecticut State University Student Health Services Form**

**FOR OFFICE USE ONLY**

**□ Complete □ Missing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Semester Beginning School Fall  Spring of \_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| ***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** #: | | | |
| **Two doses for each Measles, Mumps, Rubella & VaricellaOne dose of Meningitis Complete TB Risk and/or Test or Treatment** | | | | | | | | | | | | | | | | | | |
| **Vaccine & Date Given *OR*** | | | **Incidence of *OR* Disease** | | | | | **Titer Test Results**  **(attach lab report)** | | | | **Requirements** | | | | | | |
| **1** | **Measles #1**  or **MMR**  Date | | | Date: | | | | | Measles Titer  Date :  Result Pos  Neg | | | | ***Must be* on or after 1st birthday.** | | | | | | |
|  | **Measles #2**  or **MMR**  Date: | | | | | | | | ***Must be* at least 28 days after 1st immunization.** | | | | | | |
| **2** | **Mumps #1**   or **MMR**  Date: | | | Date | | | | | Mumps Titer  Date:  Result Pos  Neg | | | | ***Must be* on or after 1st birthday.** | | | | | | |
|  | **Mumps #2**  or **MMR**  Date: | | | | | | | | ***Must be* at least 28 days after 1st immunization.** | | | | | | |
| **3** | **Rubella #1**  or **MMR**  Date: | | | Date | | | | | Rubella Titer  Date:  Result Pos  Neg | | | | ***Must be* on or after 1st birthday.** | | | | | | |
|  | **Rubella #2**  or **MMR**  Date: | | | | | | | | ***Must be* at least 28 days after 1st immunization.** | | | | | | |
| **4** | **Varicella #1**  ***OR***  Date:  **Varicella #2**  Date: | | | **Incidence of *OR* Chicken Pox Disease**  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** (**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.** | | | | | | | | | | | | | | | | | | |
| **6** | **TUBERCULOSIS (TB) RISK QUESTIONNAIRE - A through D To be answered by the Student** | | | | | | | | | | | | | | | | | | |
| 1. 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,Anguilla,Argentina,Armenia,Azerbaijan,Bahrain,Bangladesh,Belarus,Belize,Benin,Bhutan,Bolivia,Bosnia&Herzegovina,Botswana,Brazil,Brunei,Darussalam,Bulgaria,BurkinaFaso,Burundi,Cambodia,Cameroon,CapeVerde,CentralAfricanRepublic,Chad,China,China:HongKongSpecialAdministrativeRegion,China:MacaoSpecialAdministrativeRegion,Colombia,Comoros,Congo,Côte d'Ivoire, Democratic People's Republic of Korea, Democratic Republic of the Congo,Djibouti,DominicanRepublic,Ecuador,ElSalvador,EquatorialGuinea,Eritrea,Estonia,Ethiopia,Fiji,FrenchPolynesia,Gabon,Gambia,Georgia,Ghana,Guam,Guatemala,Guinea,Guinea-Bissau,Guyana,Haiti,Honduras,India,Indonesia,Iraq,Iran,Japan,Kazakhstan,Kenya,Kiribati,Kuwait,Kyrgyzstan,LaoPeople'sDemocratic,Republic,Latvia,Lesotho,Liberia,Libyan,Arab,Jamahiriya,Lithuania,Madagascar,Malawi,  Malaysia, Maldives, Mali, Marshall Islands,Mauritania,Mauritius,Mexico,Micronesia(FederatedStates),Mongolia,Morocco,Mozambique,Myanmar(Burma),Namibia,Nauru,Niue,Nepal,Netherlands,Antilles,NewCaledonia, Nicaragua,Niger,Nigeria,NorthernMarianaIslands,Pakistan,Palau,Panama,Papua,NewGuinea,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,SierraLeone,Singapore,SolomonIslands,Somalia,SouthAfrica,SouthSudan,SriLanka,Sudan,Suriname,Swaziland,Syrian,ArabRepublic,Tajikistan, Taiwan, Thailand, The former Yugoslav Republic of Macedonia,TimorLeste,Togo,Trinidad&Tobago,Turks&Caicos,Tunisia,Turkey,Turkmenistan,Tuvalu,Uganda,Ukraine,United Republic of Tanzania, Uruguay, Uzbekistan, Vanuatu,  Venezuela(Bolivarian Republic),Viet Nam, Wallis and Futuna Islands, Yemen, Zambia ,Zimbabwe Based on WHO Global TB Report 2013 | | | | | | | | | | | | | | | | | | |
| **6.** **Prior BCG does not exempt patient from this requirement.**  If you answer **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. | | | | | | | | | | | | | | | | | | |
| **6a. TB BLOOD TEST OR**  Interferon-gamma  release assay  Date:  Result:  NEG  POS | | **6a. TB SKIN TEST Use 5TU Mantoux test only.** | | | | | | | | | **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).*** | | | | | | **6c. TB TREATMENT**  **MEDICATION (with dose):** | |
| **Date**  **Planted:** | | | | Interpretation (**If no induration, mark 0)**  NEG  POS  \_\_\_\_\_\_\_mm of induration | | | | | **Chest X-ray Date:**  Result:  Normal  Abnormal  ***(Attach copy of report)*** | | | | | | Frequency:  Start & Completion Dates: | |
| **Date**  **Read:** | | | |
| **Other Vaccination History** (Tetanus Booster within last 10 years and Hepatitis B series are recommended if not already completed) | | | | | | | | | | | | | | | | | | |
| Hepatitis B #1  Date | | | | | Hepatitis B #2  Date | | | | | Hepatitis B #3  Date | | | | | | Hepatitis Titer Result:  Date  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:** | | | | | | | | | | | | | | | | | | |
| **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**

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| ***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/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?**

**Central Connecticut State University**

**University Health Services**

**1615 Stanley Street**

**New Britain, CT 06050**

**Connecticut State University Student Health Services Form**

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 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.**