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>Incidence of Disease</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><strong>Must be on or after 1st birthday.</strong></td>
</tr>
<tr>
<td>Or MMR</td>
<td></td>
<td>Result: Pos Neg</td>
<td></td>
</tr>
<tr>
<td><strong>Mumps #1</strong></td>
<td>Date:</td>
<td>Mumps Titer Date:</td>
<td><strong>Must be on or after 1st birthday.</strong></td>
</tr>
<tr>
<td>Or MMR</td>
<td></td>
<td>Result: Pos Neg</td>
<td></td>
</tr>
<tr>
<td><strong>Rubella #1</strong></td>
<td>Date:</td>
<td>Rubella Titer Date:</td>
<td><strong>Must be on or after 1st birthday.</strong></td>
</tr>
<tr>
<td>Or MMR</td>
<td></td>
<td>Result: Pos Neg</td>
<td></td>
</tr>
</tbody>
</table>

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.

6. 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 6b., “CHEST X-RAY”, must be completed**

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

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

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

6a. **TB BLOOD TEST OR** Interferon-gamma release assay

6b. **TB SKIN TEST** Use STU Mantoux test only.

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)

I confirm that the information above is accurate.

Student consent form 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.

**Signatures**
# 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**

### Permanent Home Information

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Student Name</td>
<td>Home/Personal Email Address</td>
<td>Student Cell Phone</td>
</tr>
<tr>
<td></td>
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</tr>
</tbody>
</table>

### Notify In Case Of Emergency

<p>| | | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Home Phone</td>
<td>Cell/Work Phone</td>
<td>Name</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Relationship</td>
</tr>
</tbody>
</table>

### Street Address

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

### Personal Physician/Healthcare Provider

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Telephone #:</th>
<th>FAX #</th>
</tr>
</thead>
</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**

**Student - 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
  - 203/837-8594 Fax 203/837-8583