University of New Haven

MEDICAL INFORMATION

According to Connecticut State Law, all students born after January 1, 1957 and entering an institution of higher education MUST SHOW proof of having received immunizations for Measles, Mumps, Rubella (German Measles) and Varicella (Chicken Pox). **For your own safety and that of your classmates, you will not be permitted to register for classes or access your residence hall until the University's Health Services Office receives proof of immunity for its records.**

- **Necessary Insurance and HIPAA Information**
  - ☐ **You must provide a copy of your private insurance company card,** including company name, company phone number, and your identification number. If you do not have private insurance, please indicate that in an attached note.
  - ☐ **You must provide** a copy of your driver's license or other photo identification to be included in your patient chart.
  - ☐ **Sign the HIPAA Release Form** included in this packet, which will allow Heath Services staff to obtain your medical records in the event you need follow-up care.

- **Each full-time student is required to have a physical exam within one year prior to start of classes. Please follow the requirements listed:**
  - ☐ **Complete Physical Exam Form**
    Pages 1, 2, 3, 6 and 7 (Student)
    Pages 4 and 5 (Clinician)
  - ☐ **University of New Haven Varsity Student Athletes**
    Please note: According to NCAA guidelines, physicals for varsity student-athletes may not be dated more than six (6) months prior to becoming eligible for practice or competition. We recommend that varsity student-athletes have a physical dated April 1 or later.

- **Connecticut law requires:**
  - ☐ **MMR vaccine (Measles, Mumps, Rubella) –** two doses required or blood test to prove immunity (attach results) required. **Vaccines after December 1956 or given before the first birthday are not valid.** MMRV is also acceptable.
  - ☐ **Varicella (Chicken Pox)** — two doses required or proof of history of disease, or blood test to prove immunity (attach results) required. MMRV is also acceptable.
  - ☐ **Meningitis vaccine (MCV4 Sero Groups A, C, Y and W135) —** Proof of vaccine within five (5) years of enrollment required of all students residing in University-sponsored housing and all University of New Haven athletes, whether living on or off campus.

- **Recommended Vaccines (strongly encouraged but not required) unless specified in program major:**
  - ☐ **Tetanus: TDAP or TD vaccine within 8 years of enrollment and updated every 10 years**
  - ☐ **Hepatitis B vaccine** (3 dose series)
  - ☐ **Hepatitis A vaccine** (2 dose series)
  - ☐ **Gardasil** (HPV vaccine) 3 dose series
  - ☐ **Meningitis/Sero Group B vaccine** series
  - ☐ **Tuberculosis (TB)** screening form: If you answer yes to any questions a PPD or QuantiFERON TB gold test is required within 12 months of enrollment.
  - ☐ **Covid vaccination** (Recommended)

- **All students are REQUIRED to upload all vaccination records to CoVerified by August 1st for Fall Semester & January 1st for Spring Semester.**

If you have received the required vaccines, **please submit proof of immunity**, i.e., records from school, parents' records, or **copies of lab results of blood tests** (for Rubella, Mumps, Rubeola, and Varicella titers), along with the completed physical form.

If you have not been immunized, we suggest you contact your family physician as soon as possible.

If you were born prior to January 1, 1957, the vaccine requirement does not apply. However, we ask that you complete the physical form, circle your birth date, and return it for our records.

Please use the following link for instructions on how to upload your information to CoVerified. CoVerified Instructions

☐ Identifying Documents ☐ Health Examination & Immunization Record ☐ Vaccination Records

QUESTIONS? Contact the Health Services Office at **203.932.7079 or Email: Healthservices@newhaven.edu**

University of New Haven

HEALTH EXAMINATION REPORT

It is mandatory that all students entering the University of New Haven have a completed Health Examination Report on file, thus enabling the Health Services staff to render optimum health care when needed.

In the past several years, outbreaks of vaccine-preventable diseases on college campuses throughout the United States have resulted in many lost school days, severe complications from the diseases, anxieties for students and their parents, and large expenditures of monies to contain these outbreaks. Compliance by each student with the pre-entrance immunization policy at the University of New Haven protects the student and the general college community.

All students are required to complete the health examination report prior to the beginning of classes in the initial term of enrollment.

Pages 1, 2, 3, 6 and 7 should be completed by student prior to being examined by the clinician. Pages 4 and 5 are for the clinician to complete.

Entering term: ☐ Fall 20___ ☐ Spring 20___ ☐ Summer 20____ (grad students only)

Status: ☐ Resident ☐ Undergraduate ☐ Part-time ☐ Transfer ☐ Military Veteran ☐ Commuter ☐ Graduate ☐ Full-time ☐ High School Program

Degree Program:

Name Last First Middle Initial **ID # or Social Security #**

/ / ( ) **Birth Date** **Age** **Birth Place** **Home Phone** **Cell Phone**

Sex Assigned at Birth:_____ **Gender Identity:**_____ **Pronouns:**_____ **Chosen Name:**_____

Permanent Home Address Street

City State Zip

Local Off Campus Address or Residence Hall Street

City State Zip

If a University of New Haven athlete (or planning to be), Name of sport _____

Parent/Guardian full name #1

Address Street

City State Zip

Guardian/Spouse full name

Parent/Guardian full name #2

Address Street

City State Zip

Guardian/Spouse full name

IN CASE OF EMERGENCY NOTIFY *(Please Print)*

Full name Relationship

Address

Work Place Home Phone Cell Phone

IN THE EVENT OF SERIOUS ILLNESS OR INJURY, PARENTS OR GUARDIAN WILL BE NOTIFIED AT THE DISCRETION OF THE PROFESSIONAL STAFF.

Signature(s) Required: I certify that to the best of my knowledge that the information on this form is complete and correct.

Signature of the Student Date

Consent: I consent to medical treatment by the University Health Services Staff.

Signature of student (18 years old or older) Date

Consent for Minor (under 18 years of age):

I give my permission for medical treatment for my daughter/son if accident/illness should occur while she/he is a student at the University of New Haven. This would include referral to a local hospital which may result in her/his hospitalization, anesthesia, and surgery should it be necessary, and I am unable to be reached.

Parent or guardian's name (please print) Relationship

Signature of parent or guardian Date

University of New Haven

NAME: _____

Have you ever had or have you now any of the following: (CHECK ALL THAT APPLY and Explain YES answers on next page)

HEAD/NERVOUS SYSTEM	YES	NO	HEART, LUNGS	YES	NO	PAST HISTORY	YES	NO
Headache			High cholesterol			Operations		
Migraine			High blood pressure			Serious injury/accident		
Concussion			Heart murmur			Emotional problem/treatment		
Severe Head Injury			Palpitations			ADHD/ADD		
Seizures/convulsions			Shortness of breath			Generalized Anxiety/Social Anxiety		
Dizzy spells/fainting			Chest pain			Bipolar Disorder		
Insomnia			Asthma/wheezing			Panic Attacks		
Recurrent depression			Chronic cough			Relationship violence		
Excessive nervousness			Pneumonia			**OTHER**	**YES**	**NO**
Neuromuscular disorder			Pleurisy			Diabetes		
EARS, EYES, NOSE, THROAT	**YES**	**NO**	Bronchitis			DES exposure before birth		
Wear glasses/contact lenses			Do you smoke?			Malignant disease		
Eye injury/disease			Chest pain, dizziness or fainting with exercise			Benign tumor		
Double vision			**DIGESTIVE**	**YES**	**NO**	Anorexia Nervosa		
Deafness, hearing aid			Diarrhea, chronic/current			Bulimia		
Perforated eardrum			Colitis, ileitis			Obesity		
Repeated ear infections			Irritable bowel syndrome			Sudden weight change — gain or loss		
Repeated nose bleeds			Gallstones			Hospitalization or surgery other than tonsillectomy		
Frequent sore throats			Appendectomy			Hepatitis or jaundice		
Tonsils/Adenoids removed			Reflux/Ulcers			Hemorrhoid trouble		
Sinus trouble			Fatty Liver			Need a special diet — what kind?		
Blindness/Partial			**URINARY**	**YES**	**NO**	**INFECTIOUS DISEASE**	**YES**	**NO**
Color Blindness			Frequent urination			Mononucleosis		
BLOOD	**YES**	**NO**	Painful urination			Chicken Pox		
Anemia			Blood in urine			Measles/German Measles/Mumps		
Cancer			Recurrent urinary infection			Rheumatic fever		
Sickle cell trait or disease			Kidney infection			Scarlet Fever		
DENTAL	**YES**	**NO**	Kidney stone			COVID-19 Positive Date:		
Poor teeth/toothaches			Bladder infection			TB or positive skin test		
Bleeding gums			**BONES, JOINTS**	**YES**	**NO**	Malaria		
Gum disease			Fractures, dislocations			Whooping cough		
Bridges/braces/plates			Painful joints			Meningitis		
NECK	**YES**	**NO**	Knee problem			Sexually transmitted disease		
Swollen glands often			Arthritis			Other		
Thyroid problems/disease			Paralysis/polio			**ALLERGY**	**YES**	**NO**
SKIN	**YES**	**NO**	Joint or back injury requiring a doctor's treatment			Hay fever		
Rash			Disc problem			Food allergy		
Acne			Back problems			Medicine allergy		
Other skin diseases			Assisted Devices			Hives		

University of New Haven

NAME: _____

HABITS/LIFESTYLE	YES	NO	GYNECOLOGICAL HISTORY (Females Only)	YES	NO	GYNECOLOGICAL HISTORY (Females Only)	YES	NO
Anabolic Steroids			Age of onset Menses:			Bleeding Between Periods		
Recreational Drugs			Length of Cycle/Days:			Irregular Periods		
Alcohol			Date of last Pap Smear:			Disabled by Cramps		
Vape/Hookah			Result of last Pap Smear:			PMS		
Seizures/convulsions			Taking Contraceptive Medications/Name:			Breast Lumps		
Tobacco/Chewing Tobacco						Pregnancies		
Vegan/Vegetarian						Pelvic Inflammatory Disease		
Diet Restrictions						Gardasil Injections (series of 3) - Explain		

Explain YES answers from the charts above:

List medicines you are allergic to: _____

List foods you are allergic to: _____

Medicines (list those now taking): _____

Please note any past or present illness or conditions for which you are having or had medical care or treatment: _____

Other health problems: _____

Are you missing any organs (eyes, kidney, testicles, etc.)? _____

Explanation for YES answers with date: _____

University of New Haven

NAME: _____

Medical Examination: Required within one year prior to admission

TO THE CLINICIAN: Please review the student's history and complete the Medical Examination Form. The information will be used only as a background for providing health care and will not be released without student consent.

Examination Date: _____

Wt._____ **Ht.**_____ **BP**_____ **P**_____ **Vision:** Without glasses_____ With Glasses _____
Right 20/_____ Left 20/ _____

SYSTEM	NORMAL	DESCRIBE IF ABNORMAL
Skin		
Ears		
Nose, throat, teeth, gingival		
Neck, thyroid		
Chest, breasts		
Lungs		
Heart (describe murmur, click, etc.)		
Abdomen, liver, spleen, kidneys		
Hernia		
Genitalia		
Pelvic (if indicated)		
Rectal, Pilonidal		
Extremities, back, spine		
Lymphatic		
Neurological		
Psychological		

List all ALLERGIES (including medications, foods, insect venom, etc.): _____

Comment on type of reaction (i.e. rash, urticarial, anaphylaxis): _____

List all MEDICATIONS currently being taken: _____

_____

Comment on special dietary requirements: _____

Status of student's physical restrictions: ☐ Unrestricted ☐ Restricted ☐ Full Restriction ☐ Partial Restriction

Comment: _____

Status of student's health: ☐ Excellent ☐ Good ☐ Poor **Comment:** _____

Okay for practice and play of sports: ☐ Yes ☐ No

Past or current medical history: _____

_____

_____

_____

HEALTH CARE PROVIDER (Please print or use stamp)

Print Clinician's Name Last _____ First _____ **Phone Number** _____ **Fax Number** _____

Address Street _____ City _____ State _____ Zip _____

Clinician's Signature and Title _____

University of New Haven

NAME: _____

IMMUNIZATION RECORD: Immunity is REQUIRED prior to registration

TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER. (Dates must include month and year.) PLEASE ATTACH COPIES OF LAB RESULTS.	Date of Birth: _____ Date of Illness or Dates of Doses
TETANUS-DIPHTHERIA [ ] Completed primary series of diphtheria immunizations [ ] Tetanus-diphtheria booster required within the last 10 years [ ] Tetanus, diphtheria, pertussis	DATE:_____/_____/_____ DATE:_____/_____/_____ DATE:_____/_____/_____
MMR (MEASLES, MUMPS, RUBELLA) [ ] Dose 1 – Immunized at 12 months of age on or after 1/1/1969 [ ] Does 2 – Immunized on or after 1/1/1980 (CT State Law) [ ] Has report of immune Titer, specify date of Titer (attach copy)	DATE:_____/_____/_____ DATE:_____/_____/_____ DATE:_____/_____/_____
VARICELLA (CHICKEN POX) [ ] History of Disease - Titer proof of immunity (send lab copy) [ ] Vaccination: Two doses required	DATE_____/_____/_____ DOSE #1_____/_____/_____ DOSE #2_____/_____/_____
TUBERCULOSIS - (Check Appropriate Box) [ ] PPD (Mantoux) test within the past year (Tine or manovac not acceptable or QuantiFERON-TB Gold RESULT: [ ] POSITIVE [ ] NEGATIVE [ ] Positive PPD – Chest x-ray required. RESULT: [ ] POSITIVE [ ] NEGATIVE [ ] Treatment, if any: _____	DATE_____/_____/_____ DATE_____/_____/_____
POLIO [ ] Completed primary series of Polio immunizations Type of vaccine: [ ] Oral [ ] Inactivated [ ] E-IPV [ ] Last Booster Date	DATE_____/_____/_____ DATE_____/_____/_____
HEPATITIS A (2 doses)	DOSE #1_____/_____/_____ DOSE #2_____/_____/_____
HEPATITIS B (3 doses) [ ] Hepatitis B surface antibody DATE: Mo_____/Yr_____ [ ] Reactive [ ] Non-Reactive	DOSE #1_____/_____/_____ DOSE #2_____/_____/_____ DOSE #3_____/_____/_____
MENINGITIS VACCINATION - (MCV4 Sero Groups A, C, Y and W135**)** [ ] Menactra [ ] Other/Document Name	DATE:_____/_____/_____
MENINGITIS/SERO GROUP B VACCINE [ ] Note vaccine name:	DOSE #1_____/_____/_____ DOSE #2_____/_____/_____ DOSE #3_____/_____/_____
GARDASIL VACCINE (HPV VACCINE)	DOSE #1_____/_____/_____ DOSE #2_____/_____/_____ DOSE #3_____/_____/_____
COVID VACCINE: (Recommended) Type of vaccine: [ ] Pfizer [ ] Moderna [ ] Other: Name:_____	DOSE #1_____/_____/_____ DOSE #2_____/_____/_____

HEALTH CARE PROVIDER (Please print or use stamp)

Print Clinician's Name Last First **Phone Number** **Fax Number**

Address Street City State Zip

Clinician's Signature and Title

University of New Haven

NAME: _____

University of New Haven Tuberculosis (TB) Screening Questionnaire

Part 1: To be completed by the student. Please answer the following questions:

Tuberculosis Screening Questions	YES	NO
Have you ever had close contact with persons known or suspected to have active TB disease?		
Were you born or lived in another country besides the United States, Canada, Australia, New Zealand, or Western/Northern Europe for more than 1 month?		
Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and/or homeless shelters)?		
Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease?		
Are you currently on or plan to be on any type of immunosuppressive medication?		
Have you ever had a positive TB skin test or blood test in the past?		

If you answered **NO** to any of the above questions, no further action is necessary.

If you answered **YES** to any of the above questions, a TB test will need to be performed within 12 months of enrollment at the University of New Haven.

Part 2: To be completed by healthcare provider.

Tuberculosis Test Requirements
TB Skin Test (Mantoux Skin Test) **Date Planted:**_____ **Date Read:**_____ **Result:**_____ _____**mm of induration**
Chest X-Ray results if skin test positive (please attach copies of results) **TB Treatment: Medication:** _____ **Start Date:**___/___/____ **Dose:**_____**Completion Date: :**___/___/___
TB Blood Test (QuantiFERON TB Gold) **Date:** _____ **Result"**_____ **(Please attach copy of results)**

Please complete all information below:

Patient/Student Name:_____ Date of Birth: ____ /____ /____

Provider's Name: _____ Assessment Date: ____ /____ /____

Phone Number: _____FAX Number: _____

University of New Haven

HIPAA RELEASE FORM

Return this completed form with Medical Forms.

Dear Student:

It is important that in the event you are taken to the hospital or other off-campus medical facilities, the University of New Haven's Health Services Office must be able to obtain your medical and/or psychiatric records. These records will be used only for your medical follow-up care.

Entering term: Fall 20___ Spring 20___ Summer 20____ (grad students only)

Status: ☐ Resident ☐ Undergraduate ☐ Part-time ☐ Transfer ☐ Military Veteran ☐ Commuter ☐ Graduate ☐ Full-time ☐ High School Program

Degree Program:

Name Last First Middle Initial **ID # or Social Security #**

/ / ( ) **Birth Date** **Age** **Birth Place** **Home Phone** **Cell Phone**

Sex Assigned at Birth:_____ **Gender Identity:**_____ **Pronouns:**_____ **Chosen Name:**_____

Permanent Home Address Street

City State Zip

Local Off Campus Address or Residence Hall Street

City State Zip

If a University of New Haven athlete (or planning to be), Name of sport _____

Parent/Guardian full name #1

Address Street

City State Zip

Guardian/Spouse full name

Parent/Guardian full name #2

Address Street

City State Zip

Guardian/Spouse full name

IN CASE OF EMERGENCY NOTIFY *(Please Print)*

Full name Relationship

Address

Work Place Home Phone Cell Phone

Permission to obtain information:

I authorize the Director of Health Services or the medical staff at the University of New Haven to obtain my medical and/or psychiatric record(s) in the event that I am seen in the emergency room or other off-campus medical facilities. The information provided to the Health Services Office shall remain strictly confidential and shall not be relayed in any way to any individual or company without additional written authorization from me.

Signature(s) Required:

Signature of the Student Date

Consent for Minor (under 18 years of age):

Parent or guardian's name (please print) Relationship

Signature of parent or guardian Date