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 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 and 2 (Student)
    Pages 3 and 4 (Clinician)
  - ☐ **UNH 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:**
  - ☐ **Valid MMR injections (Measles, Mumps, Rubella) –** two injections are required, or Titre (blood test) proving immunity. Injection must be after January 1, 1969 to be valid. Example: birth date May 15, 1968, first measles injection May 15, 1969 or later. **Injections given before first birthday or prior to January 1, 1969 are not valid.**
  - ☐ **Varicella (Chicken Pox)** – history of disease with date or Titre (blood test) is required to prove immunity. Otherwise, two doses of vaccine.
  - ☐ **Tuberculosis** testing within the past twelve months.
  - ☐ **Meningitis vaccine** – Students must submit evidence of having received a meningitis vaccine not more than five (5) years before enrollment. Required of all students who will be living in university housing. Also required of all UNH athletes, whether living on or off campus.
- **Recommended Vaccines:**
  - ☐ **Hepatitis B vaccine** (3 dose series)
  - ☐ **Hepatitis A vaccine** (2 dose series)
  - ☐ **Gardasil** (HPV vaccine) 3 dose series

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 titres), 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.

QUESTIONS? Contact the Health Services Office weekdays between the hours of 8:30 a.m. and 4:30 p.m. at 203.932.7079, Fax us at 203.931.6090.

MAIL TO: Health Services Office
University of New Haven
300 Boston Post Road
West Haven CT 06516

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University of New Haven

Health Examination Report

It is mandatory that all full-time students entering UNH 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 UNH 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 full-time enrollment.

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

Entering term: ☐ Fall ☐ Summer (*grad students only*) ☐ Spring **Year** _____

Status: ☐ Resident ☐ Commuter ☐ Undergraduate ☐ Graduate ☐ Part-time ☐ Full-time

Name Last First Middle Initial

ID # or Social Security #

Birth Date

Birth Place

Home Phone

Cell Phone

☐ Male ☐ Female ☐ Other ☐ Single ☐ Widowed ☐ Married ☐ Divorced

Permanent home address Street

City State Zip

Local address Street

City State Zip

If a UNH athlete (or planning to be), name sport _____

Father's full name

Mother's full name

Father's address Street

City State Zip

Mother's address Street

City State Zip

Guardian's full name

Spouse's 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 a 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

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Have you ever had or have you now any of the following: (Explain YES answers in the space provided at bottom of page)

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

Other health problems: _____

Medicines (list those now taking): _____

List medicines you are allergic to: _____

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

Please note any illness or conditions for which you are now under treatment: _____

GYNECOLOGICAL HISTORY (FOR FEMALES ONLY)		YES	NO		YES	NO
Age of onset Menses:	Disabled by cramps			PMS		
Length of Cycle:	Irregular periods			Breast lumps		
Duration of flow – Days:	Bleeding between periods			Pregnancies		
Date of last PAP smear:	Vaginitis/discharge			Pelvic inflammatory disease		
PAP results:	Take contraceptive medications			Gardasil injections (series of 3) Document on back page		

Explanation for YES answers with date: _____

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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.

I have examined _____ **Examined on:** _____
Name of student (PRINT) 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		

PLEASE ATTACH COPIES OF LAB RESULTS.

PPD (Mantoux) skin test required within 1 year. History of having BCG vaccine is not considered contraindication.

PPD: Date placed _____ Date read _____

Result: _____ mmX _____ TX if any _____

Chest x-ray if skin text is positive or contraindicated: Date _____ Result _____

List all ALLERGIES (including medications, 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

HEALTH CARE PROVIDER (Please print or use stamp)

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

Address Street City State Zip

Clinician's Signature and Title

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IMMUNIZATION RECORD: **Immunity is REQUIRED prior to registration.**

TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER **(Dates must include month and year.)**

NAME: _____

	Month / Day / Year
A. TETANUS-DIPHTHERIA	
1. ☐ Completed primary series of tetanus diphtheria immunizations	____ / ____ / ____
2. ☐ Tetanus-diphtheria booster required within the last 10 years	____ / ____ / ____
3. ☐ Tetanus, diphtheria, pertussis	____ / ____ / ____
B. MMR (MEASLES, MUMPS, RUBELLA)	
1. ☐ Dose 1 — Immunized at 12 months of age on or after 1/1/69	____ / ____ / ____
2. ☐ Dose 2 — Immunized on or after 1/1/80 *(according to Connecticut State Law)*	____ / ____ / ____
3. ☐ Has report of immune Titre, specify date of Titre *(send copy)*	____ / ____ / ____
C. VARICELLA (CHICKEN POX)	
1. ☐ Hx of Disease ☐ Yes ____ (Year) Titre proof of immunity *(send lab copy)*	____ / ____ / ____
2. ☐ Vaccination: Two required doses: Dose #1 ____ (Month) / ____ (Year) Dose #2 ____ (Month) / ____ (Year)	
D. TUBERCULOSIS — CHECK APPROPRIATE BOX	
1. ☐ PPD (Mantoux) test within the past year *(Tine or manovac not acceptable)* Give date and test results ☐ Positive ☐ Negative	____ / ____ / ____
2. ☐ Positive PPD — Chest x-ray required. Give date and result of chest x-ray ☐ Positive ☐ Negative	____ / ____ / ____
E. POLIO	
1. ☐ Completed primary series of polio immunizations	____ / ____ / ____
Type of vaccine: ☐ Oral ☐ Inactivated ☐ E-IPV	
Last Booster:	____ / ____ / ____

F. HEPATITIS B Dose #1 ____ (Month) / ____ (Year) Dose #2 ____ (Month) / ____ (Year) Dose #3 ____ (Month) / ____ (Year)

1. Hepatitis B surface antibody ____ (Month) / ____ (Year) Reactive _____ Non-reactive _____
2. Hepatitis A Dose #1 ____ (Month) / ____ (Year) Dose #2 ____ (Month) / ____ (Year)

G. MENINGITIS VACCINATION ____ (Month) / ____ (Day) / ____ (Year) ☐ Menactra ☐ Other/document name

H. GARDASIL VACCINE (HPV VACCINE) Dose #1 ____ (Month) / ____ (Year) Dose #2 ____ (Month) / ____ (Year) Dose #3 ____ (Month) / ____ (Year)

HEALTH CARE PROVIDER (Please print or use stamp)

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

Address Street City State Zip

Clinician's Signature

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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, the University of New Haven's Health Services Office must be able to obtain your medical records. These records will be used only for your medical follow-up care.

Please Print

Name First Middle Initial Last

Date of Birth

Student ID Number or Social Security Number

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 record(s) in the event that I am seen in the emergency room. 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

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