University of New Haven | Yale NewHaven Health

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: ALL STUDENTS**
  - ☐ **You must provide a copy of your private insurance company card,** including company name, company phone number, and your identification number. All students are required to have private or university sponsored health insurance.
  - ☐ **You must provide** a copy of your driver's license, passport, or other photo identification to be included in your patient chart.
  - ☐ **If you are a minor, PLEASE SEE PAGE 8 for additional documents to be completed prior to treatment at the health center.**
- **A physical exam within one year prior to start of classes: ALL STUDENTS**
  - ☐ **Complete Physical Exam Form (To be completed by a medical professional)**
  - ☐ **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.
- **Required Immunization: ALL STUDENTS**
  - ☐ **MMR vaccine (Measles, Mumps, Rubella) –** two doses required or blood test to prove immunity (attach results) required. **Vaccines 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.
  - ☐ **TB Screening- Must be completed by all students –** If applicable, a TB skin test result must also be submitted (Part 2 of TB screening form).
  - ☐ **Meningitis vaccine (MCV4 Sero Groups A,C,Y and W135) – Only for students living on University-sponsored housing – non commuters and varsity athletes** – 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.

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 or have vaccines administered at a local pharmacy if applicable.

HOW DO I SUBMIT FORMS? What is the Process?

- **All health documents for incoming students must be submitted electronically via the site listed below. Upload your records as soon as possible to ensure you are cleared to start the semester**
- **Login to Medicat (https://ynhh.medicatconnect.com) with your University username and follow the instructions listed there.**
- **University of New Haven will eliminate holds on your Banner account after documents are successfully reviewed and completed. All records must be manually reviewed, and individuals should allow at least two (2) business days from submission for this review to occur. If University staff have questions or need you to submit additional info, you will be contacted via your University email.**

QUESTIONS? Contact the Health Services Office at **203.932.7079**

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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.

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

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

Degree Program: _____

Name Last First Middle Initial **Student ID #**

Birth Date (MM/DD/YYYY) **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 varsity 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 (Month/Day/Year)

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NAME: _____

Date of Birth (MM/DD/YYYY): _____

Health History (to be completed by a clinician)

Medication Allergies: _____

Food Allergies: _____

Medications (list those currently taking): _____

Medical Problems: _____

Past Surgeries: _____

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 | Yale NewHaven Health

NAME: _____

Date of Birth (MM/DD/YYYY): _____

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		

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

Additional Comments: _____

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 | Yale NewHaven Health

NAME: _____

Date of Birth (MM/DD/YYYY): _____

IMMUNIZATION RECORD

Immunity is REQUIRED prior to registration.

An official printed copy from your physician will be accepted in place of filling out the immunization form.

TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER. (Dates must include month and year.) **PLEASE ATTACH COPIES OF LAB RESULTS IF SUBMITTING TITIERS.**	**Date of Illness or Dates of Doses** MM/DD/YYYY
MMR (MEASLES, MUMPS, RUBELLA)	
☐ Dose 1 – Immunized on or after 12 months of age	____/____/____
☐ Dose 2 – Immunized on or after 1/1/1980 (CT State Law)	____/____/____
☐ Has report of immune Titer, specify date of Titer (attach copy)	____/____/____
VARICELLA (CHICKEN POX)	
☐ History of Disease - from physician office or Titer proof of immunity (send lab copy)	____/____/____
☐ Vaccination: Two doses required	____/____/____ (Dose #1)
	____/____/____ (Dose #2)
MENINGITIS VACCINATION - (MCV4 SERO GROUPS A, C, Y AND W135)	____/____/____
☐ Menactra ☐ Other/Document Name	

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 | Yale NewHaven Health

NAME: _____

Date of Birth (MM/DD/YYYY): _____

University of New Haven Tuberculosis (TB) Screening Questionnaire

REQUIRED FOR ALL STUDENTS

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 **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 the health care provider.

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

Please complete all information below:

Patient/Student Name: _____ **Date of Birth** (MM/DD/YYYY): ___/___/___

Provider's Name: _____ **Assessment Date** (MM/DD/YYYY): ___/___/___

Provider's Signature/ Stamp _____

Phone Number: _____ **FAX Number:** _____

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NAME: _____

Date of Birth (MM/DD/YYYY): _____

Recommended Vaccines

Proof of immunity is not required prior to registration

	Date of Illness or Dates of Doses MM/DD/YYYY
POLIO	
☐ Completed primary series of Polio immunizations	____/____/____
Type of vaccine: ☐ Oral ☐ Inactivated ☐ E-IPV	
☐ Last Booster Date	____/____/____
MENINGITIS/SERO GROUP B VACCINE	____/____/____ (Dose #1)
☐ Note vaccine name: _____	____/____/____ (Dose #2)
	____/____/____ (Dose #3)
TETANUS-DIPHTHERIA	
☐ Completed primary series of immunizations	____/____/____
☐ Td or Tdap booster recommended within the last 10 years	____/____/____
HEPATITIS A (2 DOSES)	____/____/____ (Dose #1)
	____/____/____ (Dose #2)
HEPATITIS B (3 DOSES)	____/____/____ (Dose #1)
Hepatitis B surface antibody (quantitative titer) result _____	____/____/____ (Dose #2)
Date: Month: _____ / Year: _____	____/____/____ (Dose #3)
GARDASIL VACCINE (HPV VACCINE)	____/____/____ (Dose #1)
	____/____/____ (Dose #2)
COVID VACCINE (STRONGLY RECOMMENDED)	____/____/____ (Dose #1)
Type of vaccine: ☐ Pfizer ☐ Moderna ☐ Other: _____	____/____/____ (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

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Additional Information for Minors ONLY (under 18 years of age):

If you are less than 18 years of age, you parent or guardian will need to complete two additional forms before treatment can occur at the Yale New Haven Health Nicholson Student Health Center.

The documents can be obtained on the health services website at **newhaven.edu/healthservices** under **"Health Services Requirements and Forms."**

Please ensure the following are included with your parent or guardian's signature:

1. **Patient Financial Responsibility Notice**
2. **Notice of Privacy Practices**

QUESTIONS? Contact the Health Services Office at **203.932.7079**