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 Health 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.

All students must upload their vaccination record to CoVerified by August 1st for Fall Semester & January 1st for Spring Semester (REQUIRED).

☐ Complete Covid vaccination requirements

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

HEALTH SERVICES OFFICE ● 300 Boston Post Road ● West Haven, CT 06516 ● OFFICE: 203.932.7079 ● FAX: 203.931.6090 ● www.newhaven.edu

REV. 12/21 | Produced by the Office of Marketing & Communications
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.

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**HEALTH EXAMINATION REPORT**

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

**Degree Program:**

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

**Birth Date**  
Age  
Birth Place

**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**

**Parent/Guardian full name#2**

**Address**  
Street  
City  
State  
Zip

**Guardian/Spouse full name**

**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 includereferral 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  
**Date**

---

**HEALTH SERVICES OFFICE**  
300 Boston Post Road  
West Haven, CT06516  
OFFICE: 203.932.7079  
FAX: 203.931.6090  
www.newhaven.edu

REV. 12/21 | Produced by the Office of Marketing & Communications
Have you ever had or have you now any of the following:  **(CHECK ALL THAT APPLY and Explain YES answers on next page)**

<table>
<thead>
<tr>
<th>Head/Nervous System</th>
<th>Yes/No</th>
<th>Heart, Lungs</th>
<th>Yes/No</th>
<th>Past History</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache</td>
<td></td>
<td>High cholesterol</td>
<td></td>
<td>Operations</td>
<td></td>
</tr>
<tr>
<td>Migraine</td>
<td></td>
<td>High blood pressure</td>
<td></td>
<td>Serious injury/accident</td>
<td></td>
</tr>
<tr>
<td>Concussion</td>
<td></td>
<td>Heart murmur</td>
<td></td>
<td>Emotional problem/treatment</td>
<td></td>
</tr>
<tr>
<td>Severe Head Injury</td>
<td></td>
<td>Palpitations</td>
<td></td>
<td>ADHD/ADD</td>
<td></td>
</tr>
<tr>
<td>Seizures/convulsions</td>
<td></td>
<td>Shortness of breath</td>
<td></td>
<td>Generalized Anxiety/Social Anxiety</td>
<td></td>
</tr>
<tr>
<td>Dizzy spells/fainting</td>
<td></td>
<td>Chest pain</td>
<td></td>
<td>Bipolar Disorder</td>
<td></td>
</tr>
<tr>
<td>Insomnia</td>
<td></td>
<td>Asthma/wheezing</td>
<td></td>
<td>Panic Attacks</td>
<td></td>
</tr>
<tr>
<td>Recurrent depression</td>
<td></td>
<td>Chronic cough</td>
<td></td>
<td>Relationship violence</td>
<td></td>
</tr>
<tr>
<td>Excessive nervousness</td>
<td></td>
<td>Pneumonia</td>
<td></td>
<td>Other</td>
<td></td>
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<tr>
<td>Neuromuscular disorder</td>
<td></td>
<td>Pleurisy</td>
<td></td>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>Ears, Eyes, Nose, Throat</td>
<td>Yes/No</td>
<td>Bronchitis</td>
<td></td>
<td>DES exposure before birth</td>
<td></td>
</tr>
<tr>
<td>Wear glasses/contact lenses</td>
<td></td>
<td>Do you smoke?</td>
<td></td>
<td>Malignant disease</td>
<td></td>
</tr>
<tr>
<td>Eye injury/disease</td>
<td></td>
<td>Chest pain, dizziness or fainting with exercise</td>
<td></td>
<td>Benign tumor</td>
<td></td>
</tr>
<tr>
<td>Double vision</td>
<td></td>
<td>Digestive</td>
<td>Yes/No</td>
<td>Anorexia Nervosa</td>
<td></td>
</tr>
<tr>
<td>Deafness, hearing aid</td>
<td></td>
<td>Diarrhea, chronic/current</td>
<td></td>
<td>Bulimia</td>
<td></td>
</tr>
<tr>
<td>Perforated eardrum</td>
<td></td>
<td>Colitis, ileitis</td>
<td></td>
<td>Obesity</td>
<td></td>
</tr>
<tr>
<td>Repeated ear infections</td>
<td></td>
<td>Irritable bowel syndrome</td>
<td></td>
<td>Sudden weight change — gain or loss</td>
<td></td>
</tr>
<tr>
<td>Repeated nose bleeds</td>
<td></td>
<td>Gallstones</td>
<td></td>
<td>Hospitalization or surgery other than tonsillectomy</td>
<td></td>
</tr>
<tr>
<td>Frequent sore throats</td>
<td></td>
<td>Appendectomy</td>
<td></td>
<td>Hepatitis or jaundice</td>
<td></td>
</tr>
<tr>
<td>Tonsils/Adenoids removed</td>
<td></td>
<td>Reflux/Ulcers</td>
<td></td>
<td>Hemorrhoid trouble</td>
<td></td>
</tr>
<tr>
<td>Sinus trouble</td>
<td></td>
<td>Fatty Liver</td>
<td></td>
<td>Need a special diet — what kind?</td>
<td></td>
</tr>
<tr>
<td>Blindness/Partial</td>
<td></td>
<td>Urinary</td>
<td>Yes/No</td>
<td>Infectious Disease</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Color Blindness</td>
<td></td>
<td>Frequent urination</td>
<td></td>
<td>Mononucleosis</td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td></td>
<td>Blood in urine</td>
<td></td>
<td>Chicken Pox</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td>Recurrent urinary infection</td>
<td></td>
<td>Measles/German Measles/Mumps</td>
<td></td>
</tr>
<tr>
<td>Sickle cell trait or disease</td>
<td></td>
<td>Kidney infection</td>
<td></td>
<td>Rheumatic fever</td>
<td></td>
</tr>
<tr>
<td>Dental</td>
<td>Yes/No</td>
<td>Kidney stone</td>
<td>COVID-19 Positive Date:</td>
<td>Scarlat Fever</td>
<td></td>
</tr>
<tr>
<td>Poor teeth/toothaches</td>
<td></td>
<td>Bladder infection</td>
<td></td>
<td>TB or positive skin test</td>
<td></td>
</tr>
<tr>
<td>Bleeding gums</td>
<td></td>
<td>Bones, Joints</td>
<td>Yes/No</td>
<td>Malaria</td>
<td></td>
</tr>
<tr>
<td>Gum disease</td>
<td></td>
<td>Fractures, dislocations</td>
<td></td>
<td>Whooping cough</td>
<td></td>
</tr>
<tr>
<td>Bridges/braces/plates</td>
<td></td>
<td>Painful joints</td>
<td></td>
<td>Meningitis</td>
<td></td>
</tr>
<tr>
<td>Swollen glands often</td>
<td></td>
<td>Arthritis</td>
<td></td>
<td>Sexually transmitted disease</td>
<td></td>
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<tr>
<td>Thyroid problems/disease</td>
<td></td>
<td>Paralysis/polio</td>
<td></td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td>Yes/No</td>
<td>Joint or back injury requiring a doctor's treatment</td>
<td>Hay fever</td>
<td></td>
<td></td>
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<tr>
<td>Rash</td>
<td></td>
<td>Disc problem</td>
<td></td>
<td>Food allergy</td>
<td></td>
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<tr>
<td>Acne</td>
<td></td>
<td>Back problems</td>
<td></td>
<td>Medicine allergy</td>
<td></td>
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<tr>
<td>Other skin diseases</td>
<td></td>
<td>Assisted Devices</td>
<td></td>
<td>Hives</td>
<td></td>
</tr>
<tr>
<td>HABITS/LIFESTYLE</td>
<td>YES</td>
<td>NO</td>
<td>GYNECOLOGICAL HISTORY (Females Only)</td>
<td>YES</td>
<td>NO</td>
</tr>
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</tr>
<tr>
<td>Anabolic Steroids</td>
<td></td>
<td></td>
<td>Age of onset Menses:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recreational Drugs</td>
<td></td>
<td></td>
<td>Length of Cycle/Days:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
<td>Date of last Pap Smear:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vape/Hookah</td>
<td></td>
<td></td>
<td>Result of last Pap Smear:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seizures/convulsions</td>
<td></td>
<td></td>
<td>Taking Contraceptive Medications/Name:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco/Chewing Tobacco</td>
<td></td>
<td></td>
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<tr>
<td>Vegan/Vegetarian</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Diet Restrictions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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: 
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
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/________

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

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

**TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER.**

__Dates must include month and year.__

<table>
<thead>
<tr>
<th>PLEASE ATTACH COPIES OF LAB RESULTS.</th>
<th>Date of Birth: ________________</th>
<th>Date of Illness or Dates of Doses</th>
</tr>
</thead>
</table>

### TETANUS-DIPHTHERIA
- [ ] Completed primary series of diphtheria immunizations
- [ ] Tetanus-diphteria booster required within the last 10 years
- [ ] Tetanus, diphteria, pertussis

| Date: ____/____/____ | Date: ____/____/____ | Date: ____/____/____ |

### MMR (MEASLES, MUMPS, RUBELLA)
- [ ] Dose 1 – Immunized at 12 months of age on or after 1/1/1969
- [ ] Dose 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

| 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

| DOSE #1: ____/____/____ | DOSE #2: ____/____/____ |

### 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

| DOSE #1: ____/____/____ | DOSE #2: ____/____/____ | DOSE #3: ____/____/____ |

### 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: (Required)
Type of vaccine: [ ] Pfizer [ ] Moderna [ ] Other: Name: ________________________

| DOSE #1: ____/____/____ | DOSE #2: ____/____/____ |

**HEALTH CARE PROVIDER (Please print or use stamp)**

<table>
<thead>
<tr>
<th>Print Clinician’s Name</th>
<th>Last</th>
<th>First</th>
<th>Phone Number</th>
<th>Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>Street</td>
<td>City</td>
<td>State</td>
<td>Zip</td>
</tr>
</tbody>
</table>

**Clinician’s Signature and Title**
University of New Haven Tuberculosis (TB) Screening Questionnaire

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

<table>
<thead>
<tr>
<th>Tuberculosis Screening Questions</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever had close contact with persons known or suspected to have active TB disease?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you currently on or plan to be on any type of immunosuppressive medication?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever had a positive TB skin test or blood test in the past?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Tuberculosis Test Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB Skin Test (Mantoux Skin Test)</td>
</tr>
<tr>
<td>Date Planted:_________ Date Read:_________ Result:_________ mm of induration</td>
</tr>
<tr>
<td>Chest X-Ray results if skin test positive (please attach copies of results)</td>
</tr>
<tr>
<td>TB Treatment: Medication:_________________ Start Date:<strong><strong>/</strong></strong>/____ Dose:_____ Completion Date:<strong><strong>/</strong></strong>/____</td>
</tr>
<tr>
<td>TB Blood Test (QuantiFERON TB Gold)</td>
</tr>
<tr>
<td>Date:_________ Result:__________________ (Please attach copy of results)</td>
</tr>
</tbody>
</table>

Please complete all information below:

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

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

Phone Number:________________________________________ FAX Number:_________________________________
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)

Degree Program:

Status:  □ Resident  □ Undergraduate  □ Part-time  □ Transfer  □ Military Veteran
         □ Commuter  □ Graduate  □ Full-time  □ High School 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  Parent/Guardian full name#2

Address  Street

City  State  Zip

Guardian/Spouse full name

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