CONNECTICUT COLLEGE

Student Health Services
270 Mohegan Avenue
New London, CT 06320
Tel: 860-439-2275
Fax: 860-439-5430

Certificate of Immunization

Upload to the Student Health Portal
(connc.studenthealthportal.com)
(To be completed by Healthcare Provider)

Student Name_____ **Date of Birth**_____
Last First MI

Connecticut State Law requires MMR, Varicella and Meningitis* immunizations to matriculate. Have your Healthcare Provider complete the form or attach your immunization record. Dates are required for immunizations or test results. **Please include copies of laboratory reports, if titers done.** Enter dates in **MM/DD/YYYY** format.

* **MMR** (Measles, Mumps, Rubella) **2 doses required**
#1 ____/____/_____ (*on or after 1st birthday*) **OR** Measles: 1)____/____/_____ 2)____/____/_____
#2 ____/____/_____ (*at least 28 days after 1st dose*) Mumps: 1) ____/____/_____ 2)____/____/_____
Rubella: 1) ____/____/_____ 2)____/____/_____

OR **Measles** (Rubeola) Positive titer ____/____/_____ **Result:** _____
Attach/upload copy of laboratory report

Mumps Positive titer ____/____/_____ **Result**: _____
Attach/upload copy of laboratory report

Rubella Positive titer ____/____/_____ **Result:** _____
Attach/upload copy of laboratory report

* **Varicella Vaccine** **2 doses required**

#1 ____/____/_____ (*on or after 1st birthday)* **OR** **History of Chickenpox:** Date: ____/____/_____
#2____/____/_____ (*at least 28 days after 1st dose)* **Positive Varicella Titer**: Date: ____/____/_____
Attach/upload copy of laboratory report

* **Meningococcal Conjugate Vaccine (A, C, Y, W)**: #1 ____/____/_____
#2 Booster (if vaccine given before age 16 yo): ____/____/_____

SARS COVID-19	____/____/____	____/____/____			**Indicate Manufacturer**

RECOMMENDED IMMUNIZATIONS - you may include an image of your immunization record

DTP	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
Hepatitis A	____/____/____	____/____/____			**Or Hepatitis A titer**
Hepatitis B	____/____/____	____/____/____	____/____/____		**Or Hepatitis B titer**
HPV (Gardasil)	____/____/____	____/____/____	____/____/____		
Polio *Most recent Booster*	____/____/____				
Meningitis B	____/____/____	____/____/____	____/____/____		**Indicate if Bexsero or Trumenba**
Tetanus *Booster must be in past 10 years*	**Td** ____/____/____	**Tdap** ____/____/____			

Health Care Provider *Provider/Facility Stamp Here*
Signature: _____ MD/DO/NP/PA
Print or Type Name: _____
Date: _____ Phone Number: _____
Exemptions: Download and complete **State of Connecticut Religious Exemption Form.**

CONNECTICUT COLLEGE

Tuberculosis Screening Questionnaire

(To be completed by student)

Student Health Services
270 Mohegan Avenue
New London, CT 06320
Tel: 860-439-2275
Fax: 860-439-5430

Student Name_____ **Date of Birth** _____

Last First MI

Tuberculosis (TB) risk screening is required of all domestic and International incoming students. International students who have received BCG vaccine are not exempt from the requirement for TB screening and testing.

Please answer the following questions:

1. Were you born in one of the countries or territories* listed below? If **YES**, please CIRCLE the country or territory. ☐ **YES** ☐ **NO**
2. Have you ever had close contact with persons known or suspected to have active TB disease? ☐ **YES** ☐**NO**
3. Have you ever lived or traveled for **more than 1 month** to one or more of the countries or territories listed above? If **YES**, please CIRCLE the countries or territories. ☐ **YES** ☐ **NO**
4. Have you ever had a positive Tuberculosis skin or blood test? If **YES**, your Health Care Provider is asked to complete Chest X-ray and medication treatment sections on the **TUBERCULOSIS TESTING FORM.** ☐ **YES** ☐ **NO**
5. Are you receiving immunosuppressive therapy such as tumor necrosis factor-alpha (TNF) antagonists, systemic corticosteroids ≥ 15mg of Prednisone per day, or immunosuppressive drug therapy following organ transplantation? ☐ **YES** ☐ **NO**

IF you answered ***NO*** to all of the questions above, then no further action or testing is required. TB screening is completed. Sign, date, and return the form to Student Health Services.
IF you answered ***YES*** to ANY question above, then Connecticut College requires that you complete the Connecticut College **TUBERCULOSIS TESTING FORM** with your Healthcare Provider.

Afghanistan	China, Hong Kong SAR	Haiti	Mozambique	Solomon Islands
Albania	China, Macao SAR	Honduras	Myanmar	Somalia
Algeria	Colombia	India	Namibia	South Africa
Angola	Comoros	Indonesia	Nauru	South Sudan
Anguilla	Congo	Iraq	Nepal	Sri Lanka
Argentina	Côte d'Ivoire	Kazakhstan	Nicaragua	Sudan
Armenia	DPR of Korea	Kenya	Niger	Suriname
Azerbaijan	DR of the Congo	Kiribati	Nigeria	(Swaziland)
Bangladesh	Djibouti	Kuwait	Niue	Tajikistan
Belarus	Dominican Republic	Kyrgyzstan	No. Mariana Islands	Tanzania
Belize	Ecuador	Lao PDR	Pakistan	Thailand
Benin	El Salvador	Latvia	Palau	Timor-Leste
Bhutan	Equatorial Guinea	Lesotho	Panama	Togo
Bolivia	Eritrea	Liberia	Papua New Guinea	Tunisia
Bosnia/Herzegovina	eSwatini	Libya	Paraguay	Turkmenistan
Botswana	Ethiopia	Lithuania	Peru	Tuvalu
Brazil	Fiji	Madagascar	Philippines	Uganda
Brunei Darussalam	French-Polynesia	Malawi	Portugal	Ukraine
Bulgaria	Gabon	Malaysia	Qatar	Uruguay
Burkina Faso	Gambia	Maldives	Republic of Korea	Uzbekistan
Burundi	Georgia	Mali	Republic of Moldova	Vanuatu
Cape Verde	Ghana	Marshall Islands	Romania	Venezuela
Cambodia	Greenland	Mauritania	Russian Federation	Vietnam
Cameroon	Guam	Mexico	Rwanda	Yemen
Central African-Republic	Guatemala	Micronesia-(Federated States of)	Sao Tome & Principe	Zambia
Chad	Guinea	Mongolia	Senegal	Zimbabwe
China	Guinea-Bissau	Morocco	Sierra Leone	
	Guyana		Singapore	

**Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2017. Countries with incidence rates ≥ 20 cases per 100,000 population*

Student Signature _____ Date _____

CONNECTICUT COLLEGE

Tuberculosis Testing Form

(To be completed by Healthcare Provider)

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Student Name_____ **Date of Birth** _____
Last First MI

Healthcare Provider should review the information on the **Tuberculosis Screening Questionnaire**. Students answering "YES" to any of the questions are candidates for tuberculosis (TB) screening with either a Mantoux TB skin test (**TST**) or an Interferon Gamma Release Assay (**IGRA Quantiferon**), unless a previous positive test has been documented.

-History of a positive TB skin test or IGRA blood test? (If **YES**, then document below) **YES_____ NO_____**
-History of BCG vaccination? (If **YES**, consider IGRA) **YES_____ NO_____**

TB SKIN TEST (Mantoux skin test only)

Date Planted: ____/____/_____
Date Read: ____/____/_____
Result in induration: _____ mm
If no induration, mark "0"
Interpretation: ☐ NEGATIVE ☐ POSITIVE

OR

TB BLOOD TEST: Lab report must be attached

☐ Quantiferon ☐ T-Spot
Date: ____/____/_____
Result: ☐ NEGATIVE ☐ POSITIVE
☐ INDETERMINATE ☐ BORDERLINE (T-spot Only)

CHEST X-RAY (Required if TST or IGRA Positive)

Chest X-ray Date: ____/____/_____
Chest X-ray Interpretation: ☐ NORMAL ☐ ABNORMAL
Include copy of Chest X-ray Report

MANAGEMENT OF POSITIVE TST or IGRA: Please describe treatment plan

_____

_____

_____

Health Care Provider Signature: _____ Date: _____

Health Care Provider Printed Name: _____

Address (Office Stamp): _____ Phone: _____

_____ Fax: _____

CONNECTICUT COLLEGE

Physical Examination Form

(To be completed by Healthcare Provider)

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Student Name _____ **Date of Birth**_____
Last First MI

PHYSICAL EXAM: Required of **ALL** new incoming students. To be completed by your **Healthcare Provider**.
A physical form signed and dated by a Healthcare Provider within the last 1-2 years will be acceptable.

Please list any significant **Past Medical History** or any ongoing health conditions:

_____
_____ _____

Medications: Please list current medications and dosages, including birth control and OTC medications:

_____
_____ _____

Allergy to Medication, Food or Other and **reaction:** *(if you have a medical condition that includes severe allergic reactions, you are expected to bring your individual epipen and medication to college)*:

_____
_____

Surgical History: _____

Height: _____ **Weight:** _____ **BP**_____/_____ **Pulse**_____

Recommendation for participation in Club, Intramural, or Recreational Sporting Contests:

Unlimited: ___ Limited: ___ If limited, please explain: _____

	NORMAL	ABNORMAL	Comment on abnormal
SKIN			
HEENT			
NECK/THYROID/LYMPH			
RESPIRATORY			
CARDIOVASCULAR			
ABDOMEN (include hernia)			
GENITOURINARY			
MUSCULOSKELETAL			
NEUROLOGIC			
PSYCHOLOGICAL			

HEALTH CARE PROVIDER:
Signature _____**Date of Exam:** _____
Name (or stamp) _____ Phone#_____
Address_____ Fax#_____

CONNECTICUT COLLEGE

Consent to Treat Minor

(To be completed by Parent/Guardian of Minor)

Student Health Services
270 Mohegan Avenue
New London, CT 06320
Tel: 860-439-2275
Fax: 860-439-5430

Student Name _____ **Date of Birth**_____
Last First MI

I, _____, authorize Connecticut College Student Health Services to provide medical treatment and services, or when circumstances require immediate action, to proceed according to medical practices. This consent remains in effect until my student, _____, reaches age 18. I understand I will be informed, in a timely manner, of medical treatment and any emergency care provided.

_____ _____

Parent/Guardian Signature Date