STUDENT HEALTH SERVICES

Name: **Date of Birth:**

UNIVERSITY OF BRIDGEPORT
STUDENT HEALTH SERVICES HEALTH FORM A

MANDATORY FOR ALL UNDERGRADUATES, HEALTH SCIENCES STUDENTS, AND INTERNATIONAL STUDENTS

The appropriate health report must be submitted by all students with the exception of distance learning. Registration at the University cannot be confirmed until this form has been accepted as complete by Student Health Services. Parts A and B should be completed by the student prior to being examined by the physician/health care provider.

Entering Semester: ☐ Fall ☐ Spring Y Y Y Y Status: ☐ Resident ☐ Off-campus student

University of Bridgeport Student ID | UB Email | Program

Students joining NCAA teams should fill out the sports form that can be found on **bridgeport.edu**.

PART A: STUDENT INFORMATION

PLEASE PRINT ALL INFORMATION

Last Name | First Name | Middle Initial

Cell Phone | Home Phone

Birth Date M M D D Y Y Y Y | Birthplace

Permanent Home Address | City | State | ZIP Code

Mailing Address | City | State | ZIP Code

Marital Status: ☐ Single ☐ Widowed ☐ Married ☐ Divorced

Major _____ Date of entry to U.S. M M D D Y Y Y Y

Varsity Team Sport(s) _____ Gender: ☐ Male ☐ Female

IN CASE OF EMERGENCY, NOTIFY:

Last Name | First Name | Relationship

Address | City | State | ZIP Code

Business Phone | Home Phone | Cell Phone

☐ **I hereby grant permission to the Health Services personnel to contact the person named above in the event of a medical emergency.**

Student Signature _____ Date M M D D Y Y Y Y

MANDATORY INSURANCE COVERAGE

The University of Bridgeport Health Insurance policy is mandatory for all international students, all students in campus housing, students in the Physician Assistant program, and all full-time undergraduate students. Only domestic students have the option to apply for an insurance waiver. Waivers will only be approved if the domestic student provides documentation of comparable health insurance and a valid insurance card.

PART B: STUDENT AUTHORIZATION FOR TREATMENT AT UB HEALTH SERVICES

I hereby authorize the University of Bridgeport Student Health Services to provide medical treatment and services as they deem appropriate. This authorization will remain in effect as long as I am a registered student at the University of Bridgeport.

Student Signature _____ Date M M D D Y Y Y Y

(Must be 18 years of age or older)

Signature of Parent or Guardian _____ Date M M D D Y Y Y Y

(If student is under 18 years of age)

STUDENT CONSENT FOR TREATMENT REQUIRED TO BE SIGNED

(if you are less than 18 years of age, signatures of both the student and one parent/guardian are required)

I hereby grant permission for the University of Bridgeport Health Services staff to provide me with appropriate medical and mental health treatment including medications for treatment of illnesses/injuries and to arrange for any emergency medical care if circumstances at that time make it impossible to make such decisions.

Signature of Parent or Guardian _____ Date M M D D Y Y Y Y

Following the prompt completion of this medical form, mail, fax, or email a scanned copy to the following address:

University of Bridgeport
Student Health Services
60 Lafayette Street, Room 116
Bridgeport, CT 06604

Tel: 203.576.4712
Fax: 203.576.4715
Email: healthservices@bridgeport.edu

PART C: VACCINE REQUIREMENTS FOR ALL STUDENTS

THIS SECTION IS TO BE COMPLETED BY THE PHYSICIAN/HEALTH CARE PROVIDER AND IS MANDATORY FOR ALL STUDENTS.

The following immunizations and tests are mandatory prior to registration and to reside in on-campus housing.

☐ **Meningococcal Vaccine (A, C, Y, W-135)** M M D D Y Y Y Y *Mandatory if living on campus, must have been given in past 5 years.*

☐ **MMR (Measles, Mumps, Rubella)** *Not required for students born before January l, 1957.*

Two measles, mumps, and rubella vaccines are required. Both vaccination dates must be listed.

M M D D Y Y Y Y
1st Immunization (First vaccine at or after 12 months of age or after 1/1/69)

M M D D Y Y Y Y
2nd Immunization (Second vaccine required on or after 1/1/80)

OR **Antibody titer for measles, mumps, and rubella**
You must provide proof of immunity with lab slip. Attach lab slip if titer is being used to complete this requirement.

☐ **Varicella (Chickenpox)** *Not required for students born in the United States before 1980.*

Two varicella vaccines are required. Both vaccination dates must be listed.

M M D D Y Y Y Y
1st Immunization Date

M M D D Y Y Y Y
2nd Immunization Date

(Second dose given at least 12 weeks after first dose, if that was given at 1–12 years, or at least 4 weeks after first dose, if that was given at 13 years or older)

OR Antibody titer for varicella *You must provide proof of immunity with lab slip. Attach lab slip if titer is being used to complete this requirement.*

OR Confirmed case of disease *by physician/health care provider or public health director in student's present/previous town of residence.*

M M D D Y Y Y Y
Date of Illness

☐ **COVID-19 Vaccine** Type _____

1st Dose M M D D Y Y Y Y 2nd Dose M M D D Y Y Y Y Booster ☐ Yes ☐ No M M D D Y Y Y Y

☐ **Tuberculin/PPD or IGRA** *Interferon Gamma Release Assay*

Required within 6 months of registration. History of having BCG vaccine is not considered a contraindication.

PPD Date Given M M D D Y Y Y Y PPD Date Read M M D D Y Y Y Y Result _____ MM

IGRA Date M M D D Y Y Y Y Result _____

Any history of positive PPD? ☐ No ☐ Yes Date M M D D Y Y Y Y

PART C: VACCINE REQUIREMENTS (CONTINUED)

If positive history of PPD or IGRA, the following information is MANDATORY.

1. Prophylactic treatment dates M M D D Y Y Y Y to M M D D Y Y Y Y

OR Reason for non-treatment _____

2. Chest x-ray required if PPD not done or if skin test/IGRA is positive. Chest x-ray date M M D D Y Y Y Y Result _____

RECOMMENDED VACCINES

Flu Vaccine M M D D Y Y Y Y

It is highly recommended that students obtain the health requirements and health records of the vaccines from their primary doctor. Some vaccines are not available in UB Student Health Services and may be high in cost.

PART D: REQUIRED FOR ALL CLINICAL HEALTH SCIENCE AND NURSING STUDENTS

(Excluding Pre-Nursing)

SELECT ONE PROGRAM:

- ☐ School of Chiropractic
- ☐ Medical Lab Science
- ☐ Acupuncture Institute
- ☐ Pre-Dental Hygiene
- ☐ Fones School of Dental Hygiene
- ☐ Physician Assistant Institute
- ☐ School of Nursing

VACCINES REQUIRED

☐ **Tetanus, Diphtheria Pertussis (TdaP)** *Must be within the past 10 years.* M M D D Y Y Y Y

☐ **Hepatitis-B Vaccine** *Series of 3 doses*

M M D D Y Y Y Y Dose #1 | M M D D Y Y Y Y Dose #2 | M M D D Y Y Y Y Dose #3

☐ **Hepatitis-B/Quantitative Titer (Must attach titer)**

☐ **Flu Vaccine** M M D D Y Y Y Y

TUBERCULOSIS SCREENING REQUIRED **Two-Step PPD or IGRA**

☐ **PPD Tuberculin skin test (Mantoux)** *Two-step PPD required (1–3 weeks apart)*

PPD #1

M M D D Y Y Y Y Date placed | M M D D Y Y Y Y Date read | Result _____ mm duration ☐ Positive ☐ Negative

PPD #2

M M D D Y Y Y Y Date placed | M M D D Y Y Y Y Date read | Result _____ mm duration ☐ Positive ☐ Negative

If PPD is positive at either reading, a chest x-ray is required and "Tuberculosis–Statement of Treatment"* must be filled out by the provider.
Form can be found at **bridgeport.edu/healthforms.*

OR ☐ **Blood Assay for M. tuberculosis (IGRA)**

Provide documentation of a negative IGRA performed within the previous 6 months ☐ Yes ☐ No

IGRA date M M D D Y Y Y Y Result ☐ Positive ☐ Intermediate ☐ Negative

If IGRA is positive, a chest x-ray is required and "Tuberculosis–Statement of Treatment"* must be filled out by the provider. **Form can be found at **bridgeport.edu/healthforms.***

PART E: TO THE PHYSICIAN/HEALTH CARE PROVIDER

This section is to be completed by the physician/health care provider and is mandatory for all students. Please review the student's history and complete the Health Examination Report. This information will be used only as background for providing health care and will not be released without the student's consent.

I have examined _____ Date M M D D Y Y Y Y
Last Name First Name Middle Initial

History of present illness (i.e., asthma, diabetes)_____

Current or past medical history (i.e., illnesses, surgeries, injuries, psychiatric conditions) _____

PART E: TO THE PHYSICIAN/HEALTH CARE PROVIDER (CONTINUED)

Social history _____

Indicate location and dates of travel within the past year _____

Family medical history (i.e., diabetes, hypertension, heart disease, cancer, etc.) _____

_____

List all allergies (including medication, insect venom, etc.) _____

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

List all medications currently being taken, including vitamins and supplements _____

If the student has a severe food allergy, please encourage him/her to take a tour of allergy-friendly options on campus by emailing diningservices@bridgeport.edu

Is the student allergic to latex? ☐ Yes ☐ No Is an EpiPen prescribed? ☐ Yes ☐ No

Does the student wear glasses/contacts? ☐ Glasses ☐ Contacts M M D D Y Y Y Y Date of last eye exam Specify reason _____

PHYSICAL EXAM

Weight	Blood Pressure
Height	Pulse Temp
Glasses	Extremities
Contacts	Vision (R) (L)
General	Hearing (R) (L)
Skin	Back/Spine
HEENT	Genito/Urinary
Neck	Vascular
Lungs	Lymphatic
Heart	Neurologic
Chest	Abdomen

URINALYSIS

Protein _____ Sugar _____ Blood _____ Other _____

Laboratory Findings _____

HGB _____ or HCT _____ Any other lab results _____

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

Comments _____

Are there any limitations regarding this student's participation in school or residing on campus? ☐ Yes ☐ No

If yes, please specify _____

Clinical impression _____

Recommendations _____

PHYSICIAN/HEALTH CARE PROVIDER'S INFORMATION (*please print*)

Last Name First Name Middle Initial Telephone

Address City State ZIP Code

Physician/Health Care Provider's Signature _____ Date of Exam M M D D Y Y Y Y