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 (within 5 years of entering college): ____/____/_____

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

SARS COVID-19	____/____/____	____/____/____	____/____/____	____/____/____	**Indicate if Monovalent or Bivalent**
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 Phone: _____
Print or Type Name: _____ Date: _____

Exemptions: Download and complete:
https://www.conncoll.edu/campus-life/student-health-services/record-requests-and-forms/

Hartford HealthCare | Connecticut College

Tuberculosis Testing Form

(To be completed by Healthcare Provider)

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Student Name_____ **Date of Birth** _____
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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 TB blood test (IGRA)? If **YES**, then document below. **YES_____ NO_____**
-History of BCG vaccination? (If **YES**, consider IGRA) **YES_____ NO_____**

TB SKIN TEST (Mantoux skin test only) **OR**

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

TB BLOOD TEST (IGRA): 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: _____

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Physical Examination Form

(To be completed by Healthcare Provider)

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#_____

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Consent to Treat Minor

(To be completed by Parent/Guardian of Minor)

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 standard medical practices. This consent remains in effect until my student, _____, reaches age 18.

I understand I will be informed, in a timely manner, of any emergency care that is provided or medically indicated.

_____ _____

Parent/Guardian Signature Date