

## IMMUNIZATION FORM UNDERGRADUATE

Please have your healthcare provider complete and sign this form. Bring this form with you along with a copy of your immunization records.

**THIS FORM MUST BE ON FILE PRIOR TO START OF CLASSES OR MOVING ONTO CAMPUS.**

\*This is the only form we will accept.

### Student Information

This section must be completed

Name	<input type="text"/>					
Date of Birth	<input type="text" value="MM"/>	<input type="text" value="DD"/>	<input type="text" value="YYYY"/>	Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Date Entering University	<input type="text" value="MM"/>	<input type="text" value="DD"/>	<input type="text" value="YYYY"/>	Status	<input type="checkbox"/> Full time	<input type="checkbox"/> Part time
Cellphone	<input type="text"/>				Student ID#	<input type="text"/>
Email	<input type="text"/>					

### Permanent Home Information

Address	<input type="text"/>		
	<input type="text"/>	Zip Code	<input type="text"/>

### Notify in Case of Emergency: (Relationship)

Name	<input type="text"/>		
Phone	<input type="text"/>	Relationship	<input type="text"/>

State of Connecticut and The University of Hartford REQUIRE:

**Two doses of MMR (Measles, Mumps, Rubella) | Two doses of Varicella | One dose of Meningitis\***

First dose must be on or after 1st birthday

#### MEASLES/ MUMPS/ RUBELLA (MMR)

MMR exemption if born prior to 12/31/1956

Dose 1	<input type="text" value="MM"/>	<input type="text" value="DD"/>	<input type="text" value="YYYY"/>	Dose 2	<input type="text" value="MM"/>	<input type="text" value="DD"/>	<input type="text" value="YYYY"/>		
<input type="checkbox"/>	OR positive blood titer with REQUIRED copy of lab report.			Date	<input type="text" value="MM"/>	<input type="text" value="DD"/>	<input type="text" value="YYYY"/>	<input type="checkbox"/> Pos	<input type="checkbox"/> Neg

#### Varicella

Varicella is required only for students born on or after January 1, 1980

Dose 1	<input type="text" value="MM"/>	<input type="text" value="DD"/>	<input type="text" value="YYYY"/>	Dose 2	<input type="text" value="MM"/>	<input type="text" value="DD"/>	<input type="text" value="YYYY"/>		
<input type="checkbox"/>	OR Incidence of disease Chicken Pox			Date	<input type="text" value="MM"/>	<input type="text" value="DD"/>	<input type="text" value="YYYY"/>	Provider initials	<input type="text"/>

#### MENINGOCOCCAL VACCINE (MCV4)

Meningococcal Vaccine (MCV4) is required for all students living in campus housing. (It is strongly recommended for all students) Vaccine must be within 5 years of entry. The vaccine is no longer effective after 5 years and a booster may be required.

<input type="text" value="MM"/>	<input type="text" value="DD"/>	<input type="text" value="YYYY"/>	<input type="checkbox"/> I will not be living in campus housing
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### Other Vaccine History

Varicella is required only for students born on or after January 1, 1980

Hepatitis B #1    Hepatitis B #2     
Hepatitis B #3    Hepatitis B Titer     Pos  Neg

Last Tetanus  Td  Tdap Date

HPV: Date #1     
HPV: Date #2     
HPV: Date #3

### Other Vaccination

Date of last Physical

### Clinician

**I confirm that the information above is accurate.**

Must be signed and stamped by Healthcare Provider

Clinician Name:

Signature  Date

Address

Zip Code

Phone

Fax

**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)

Student Signature  Date

Signature of Parent/Guardian  Date

Continued

### Personal Medical History

Please check all that apply

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Acne                         | <input type="checkbox"/> Cerebral Palsy            | <input type="checkbox"/> Insomnia/Sleep prob   |
| <input type="checkbox"/> Alcohol/drug use             | <input type="checkbox"/> Chronic Bronchitis        | <input type="checkbox"/> Kidney stones/disease |
| <input type="checkbox"/> Anemia                       | <input type="checkbox"/> Depression                | <input type="checkbox"/> Menstrual Problems    |
| <input type="checkbox"/> Anxiety                      | <input type="checkbox"/> Diabetes Type I / Type II | <input type="checkbox"/> Migraine/Headaches    |
| <input type="checkbox"/> Arthritis                    | <input type="checkbox"/> Eating disorder           | <input type="checkbox"/> Phlebitis             |
| <input type="checkbox"/> Bleeding trait               | <input type="checkbox"/> Hay fever/Allergies       | <input type="checkbox"/> Rheumatic fever       |
| <input type="checkbox"/> Bipolar                      | <input type="checkbox"/> Hepatitis                 | <input type="checkbox"/> Seizure disorder      |
| <input type="checkbox"/> Breast disease               | <input type="checkbox"/> Heart disease             | <input type="checkbox"/> Skin disorder         |
| <input type="checkbox"/> Cancer                       | <input type="checkbox"/> High Cholesterol          | <input type="checkbox"/> Tobacco user          |
| <input type="checkbox"/> Residential Life Information | <input type="checkbox"/> HIV/AIDS                  | <input type="checkbox"/> Other                 |

### Allergies

Drug and other Severe Adverse Reactions

Are any life threatening?  Yes  No      Do you carry an Epi Pen?  Yes  No

#### Prior Hospitalizations or Surgeries

Please list dates and reasons

#### Medications—Frequent or regular

Please list all prescriptions, natural and over the counter medications.

#### Current Medical History

Conditions that we should know about?

### Insurance Information

Name of Carrier:	<input type="text"/>			
Policy #	<input type="text"/>	Group #	<input type="text"/>	
Policy Holder	<input type="text"/>	Policy Holder's DOB	<input type="text" value="MM"/>	<input type="text" value="DD"/>
RX #	<input type="text"/>	Bin	<input type="text"/>	

Parent/Guardian: Please note we cannot discuss any health information with you without the student's written consent if they are 18 or over. The consent must be completed in our office at the time of the visit. The student has a right to refuse. Thank you for your understanding.

**All forms must be turned into the IPP staff during the Orientation program beginning August 30, 2018, You will NOT be able to move into campus housing and/or start classes unless fully compliant.**