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
completed by Healthcare Provider)

Hartford HealthCare

(To be

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/

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Tuberculosis Screening Questionnaire

(To be completed by student)

Hartford HealthCare

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, Connecticut College requires that you complete the Connecticut College **TUBERCULOSIS TESTING FORM** with your Healthcare Provider.

Afghanistan
Algeria
Angola
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
China, Hong Kong Special Administrative Region
China, Macao Special Administrative Region
Colombia
Comoros
Congo
Côte d'Ivoire
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Eswatini
Ethiopia
Fiji
Gabon
Gambia
Georgia
Ghana
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Kyrgyzstan
Lao People's Democratic Republic
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mexico
Micronesia
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Niue
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Sao Tome and Principe
Senegal
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Tajikistan
Thailand
Timor-Leste
Togo
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

**Source: World Health Organization Global Health Observatory, Tuberculosis Incidence as of 10/26/23. Countries with incidence rates ≥ 20 cases per 100,000 population.*

Student Signature _____ Date _____

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Tuberculosis Testing Form

(To be completed by Healthcare Provider)

Hartford HealthCare

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: _____

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Physical Examination Form

(To be completed by Healthcare Provider)

Hartford HealthCare

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