Instructions for Quinnipiac University Student Health Services Requirements

1. **Immunization Form**: Bring to a health care provider to complete. Our immunization form outlines the REQUIRED vaccines. If you obtain a copy of your immunization record from your own physician, prior school, or military, please be certain that your records include: 2 MMR’s (measles, mumps & rubella), 2 Varicella vaccines – or history of disease; one conjugate Meningitis vaccine – given within 5 years of the first day of class. One current tetanus vaccine – within 10 years.

2. **Tuberculosis Screening & Testing Form**: Part 1 to be answered by the student. Part II to be completed and signed by a health care provider.
   **IMPORTANT**: Part 1, Tuberculosis Screening must be submitted to Health Services even if all answers on the form are “No”.

3. **Physical Exam Form**: Current physical exam within 2 years of the first day of class, to be completed and signed by your Health Care Provider (MD, PA, APRN).

4. **Consent and Signature page**: Consent to treat to be signed by student and parent (if student is under age 18). This page includes important treatment and practice notifications.

Students are responsible for completing their Student Health Online Requirements through QStart. You will need your QU username and password to access QStart.

5. **Online Personal Form**: To be completed before your orientation. Access through QStart or https://studenthealthservices.quinnipiac.edu. Please let us know about any health issues, medications, and allergies you have.

6. **Online Immunizations**: Click on the Immunization link – access through QStart or above link. Be sure to keep a copy of your completed immunization form so you can complete the online portion of your health requirements.

Once all items are checked, please mail all forms together to:

Quinnipiac University
Student Health Services, IR-HLT
275 Mt. Carmel Avenue
Hamden, CT 06518.

- YOUR COMPLETED FORMS AND ONLINE COMPONENTS ARE REQUIRED TO AVOID REGISTRATION AND CLASS GRADING HOLDS.

- MAIL IS THE PREFERRED DELIVERY METHOD FOR YOUR HEALTH FORMS. Due to the high volume of paperwork we receive, please allow 2-3 weeks for processing.

- *ATHLETES NOTE* Student health forms are separate from your Athletic Forms. Please bring both to your doctor when you have your physical!

- Program requirements are separate from Student Health Services requirements.
**IMMUNIZATION FORM**

**REQUICK IMMUNIZATIONS**

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Date of Immunization</th>
<th>Varicella (Chicken Pox) History of Disease, 2 doses required or titer</th>
<th>Tetanus-Diphtheria Booster 1 dose required or titer</th>
<th>Mumps</th>
<th>Measles (Rubeola)</th>
<th>Rubella (German measles)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meningococcal conjugate vaccine</td>
<td></td>
<td>(Within past 5 years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella (Chicken Pox) History of disease</td>
<td></td>
<td>Given on or after 1st birthday</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetanus-Diphtheria Booster</td>
<td></td>
<td>Given on or after 1st birthday and after 1/1/69</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMR (Measles, Mumps, Rubella)</td>
<td></td>
<td>Given on or after 1st birthday and after 1/1/69</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If given separately or proof of immunity by titer</td>
<td></td>
<td>Given on or after 1st birthday and after 1/1/69</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**RECOMMENDED IMMUNIZATIONS** (not required)

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Date of Immunization</th>
<th>Varicella (Chicken Pox) History of Disease, 2 doses required or titer</th>
<th>Tetanus-Diphtheria Booster 1 dose required or titer</th>
<th>Mumps</th>
<th>Measles (Rubeola)</th>
<th>Rubella (German measles)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serogroup B Meningococcal 2 OR 3 Dose Series</td>
<td></td>
<td>Bexsero OR 2 Dose Series</td>
<td>Trumenba 3 Dose Series</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B 3 Dose Series</td>
<td></td>
<td>Date of Dose #1</td>
<td>Date of Dose #1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A 2 Dose Series</td>
<td></td>
<td>Date of Dose #1</td>
<td>Date of Dose #1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HPV (Gardasil)</td>
<td></td>
<td>Date of Dose #1</td>
<td>Date of Dose #1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio (Most recent Booster)</td>
<td></td>
<td>Date of Booster</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Typhoid</td>
<td></td>
<td>Date</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Health Care Provider Signature/Stamp (REQUIRED)**

_Signature of Health Care Provider (MD/DO/PA/NP)_

_Date_

_Telephone Number_

_Printed/Typed Name of Health Care Provider_
PART I

TUBERCULOSIS SCREENING QUESTIONNAIRE AND TESTING REQUIREMENTS (Questions 1-5 to be answered by student)

1. Were you born in one of the countries listed below? (If yes, please CIRCLE the country)
   - YES ☐ NO ☐

2. Have you ever lived as a resident or traveled for more than a month in a country with
   High TB rates (countries below)? If yes, CHECK the countries below and provide date(s)
   of travel/residence
   - YES ☐ NO ☐
   Date:

3. Have you ever had a positive tuberculosis skin or blood test? If yes, provider is asked to
   complete chest x-ray and medication treatment sections below
   - YES ☐ NO ☐

4. Have you ever injected drugs or resided/worked in high risk settings such as prisons,
   nursing homes, orphanages, AIDS facilities, health care facilities, or homeless shelters?
   (If yes, provide dates)
   - YES ☐ NO ☐
   Date:

5. Do you have a clinical condition such as HIV, diabetes, chronic renal failure, leukemia,
   lymphoma, significant unexplained weight loss, gastrectomy, jejunoileal bypass,
   silicosis, prolonged immunosuppressant therapy (e.g. prednisone 15mg/d for 1 month),
   head neck or lung cancer, or other immunosuppressive disorders?
   - YES ☐ NO ☐

*If the answer is NO to all the above questions, no further testing is needed. Sign and return to Student Health Services.

Student Signature
Date

*If the answer is YES to any of the above questions, TB testing is REQUIRED. Take this form to your Health Care
Provider to complete and sign Part II on page 3.

| Afghanistan | Côte d'Ivoire | Japan | Nicaragua | Sudan |
| Algeria | Croatia | Kazakhstan | Niger | Suriname |
| Angola | Democratic People's Republic of Korea | Kenya | Nigeria | Swaziland |
| Argentina | Democratic Republic of the Congo | Kiribati | Pakistan | Syrian Arab Republic |
| Armenia | Djibouti | Kuwait | Palau | Tajikistan |
| Azerbaijan | Dominican Republic | Kyrgyzstan | Papua New Guinea | Thailand |
| Bahrain | Ecuador | Lao People's Democratic Republic | Paraguay | The former Yugoslav |
| Bangladesh | El Salvador | Latvia | Peru | Republic of |
| Belarus | Equatorial Guinea | Lesotho | Philippines | Macedonia |
| Belize | Eritrea | Liberia | Poland | Timor-Leste |
| Benin | Ethiopia | Libyan Arab Jamahiriya | Portugal | Togo |
| Bhutan | Eritrea | Lithuania | Qatar | Tunisia |
| Bolivia (Plurinational State of) | Estonia | Madagascar | Turkey | Turkmenistan |
| Bosnia and Herzegovina | Ethiopia | Malawi | Tuvalu | Uganda |
| Botswana | Fiji | Malaysia | Ukraine | United Republic of |
| Brazil | Gabon | Maldives | United Arab Emirates | Tanzania |
| Brunei Darussalam | Gambia | Mali | Uruguay | Uganda |
| Bulgaria | Georgia | Marshall Islands | Uzbekistan | Vanuatu |
| Burkina Faso | Ghana | Mauritania | Venezuela (Bolivarian Republic of) | Viet Nam |
| Burundi | Guatemala | Mauritius | Viet Nam | Yemen |
| Cambodia | Guinea | Micronesia (Federated States of) | Yemen | Zambia |
| Cameroon | Guinea-Bissau | Mongolia | Zimbabwe | Zimbabwe |
| Cape Verde | Guyana | Morocco | | |
PRINT NAME (LAST) ___________________________ (FIRST) ___________________________ MI ___ DOB ________

PART II

TO BE COMPLETED BY HEALTH CARE PROVIDER if answered “yes” to any of the questions on Page 2.

TB SKIN TEST (Mantoux skin test only)

Date Planted: _____/_____/_____
Date Read: _____/_____/_____
Result in induration _________ mm
If no induration, mark “0”

OR

TB BLOOD TEST: LAB REPORT MUST BE ATTACHED.

☐ Quantiferon   ☐ T-Spot

Date: _____/_____/_____
Result: ☐ NEG ☐ POS
☐ INDETERMINATE

CHEST X-RAY IF SKIN OR BLOOD TEST IS POSITIVE

CHEST X-RAY: INCLUDE A COPY OF CHEST X-RAY REPORT. IF MORE THAN ONE YEAR OLD, MUST COMPLETE PPD QUESTIONNAIRE AT QUINNIPIAC UNIVERSITY STUDENT HEALTH SERVICES UPON ARRIVAL TO CAMPUS.

Chest X-Ray Date: _____/_____/_____
Result: ☐ NORMAL ☐ ABNORMAL

MEDICATION TREATMENT

☐ Latent (inactive)

☐ Active TB Disease

Type of tx: ___________________________
Duration: __________
Treatment completion date: _____/_____/_____

________________________________________
Signature of Health Care Provider

Date

________________________________________
Printed/Typed Name of Health Care Provider

Address (Please print or stamp)

________________________________________
Phone: _________________________________

________________________________________
Fax: _________________________________
PHYSICAL EXAMINATION FORM

PRINT NAME (LAST) ___________________________ (FIRST) ___________________________ MI _____ DOB ________

This Section Is To Be Completed By A Health Care Provider (Within 2 Years of Enrollment Date)

Ht. ______ Wt. ______ BP ______ Pulse ______

CLINICAL EXAMINATION

<table>
<thead>
<tr>
<th>Check each item in proper column: Enter NE if not evaluated</th>
<th>Normal</th>
<th>Abnormal</th>
<th>If abnormalities are noted, please describe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neck</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HEENT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs, chest, breast</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart (include any murmur/defect)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen (include hernia)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Genitalia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal/Extremities</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Skin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurologic</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Psychiatric</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ALLERGY TO: (Please circle YES or NO)

Medication: YES NO (if yes, please list)

Foods: YES NO (If yes, please list)

Other:

Does Patient Need To Carry An EpiPen? □ YES □ NO

CURRENT MEDICATIONS: Please list any prescription and over the counter medications, including birth control pills:

___________________________________________________________________________

___________________________________________________________________________

Please note any significant past medical history or any ongoing problems:

___________________________________________________________________________

Clearance for participation in:

☐ All sports at Quinnipiac University without restriction.

*Athletes are required to complete additional forms available through QU Athletics website.

PROVIDER INFORMATION & SIGNATURE REQUIRED

I have conducted a physical examination of this patient within the past 2 years.

DATE OF EXAM: ___________________________

Signature of Health Care Provider

Degree

ADDRESS: (Please print or stamp):

Phone: ___________ Fax: ___________
Student Health Services  
Consent and Signature Page

Final Checklist:

☐ Immunization Form – Page 1
☐ Tuberculosis Screening and Testing Form – Page 2 & 3
☐ Physical Exam Form – Page 4
☐ Consent and Signature Page – Page 5
☐ On Line Personal Form
☐ On Line Immunization Form

Student Name: ___________________________  DOB: ___________________________

(Please print)

Notifications and Consent to Treat

Services are available only to students who have a physical exam and all required forms including the Online Personal Form and the Immunization Record completed and on file in the Student Health Services.

Student Health Services does not participate in third party insurance billing. All charges for referrals, diagnostic procedures and lab work will be billed directly to the student at the student’s home address. Quest Diagnostics is the default laboratory unless the student advises the healthcare provider at the time of service.

Students should have a copy of their current health insurance card with them at all times.

The purpose of this form is to assist Student Health Services in providing medical treatment and services as they deem appropriate. This authorization will remain in effect as long as I am a student at Quinnipiac University.

IN THE EVENT OF SERIOUS ILLNESS OR INJURY, PARENTS OR GUARDIAN WILL BE NOTIFIED AT THE DISCRETION OF THE PROFESSIONAL STAFF.

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 authorize for Quinnipiac University Health Services staff to provide me with appropriate medical and mental health treatment including medications for treatment of illness/injuries and to arrange for any emergency medical care if circumstances at that time make it impossible for me to make such decisions. Furthermore, I understand that Student Health Services staff may disclose my student medical records and/or information from such records to appropriate University personnel and/or Emergency Contacts identified within my records in the event of a health or safety situation as determined by the Student Health Services staff.

Signature of Student (Required)  __/__/____ Date  Signature of Parent or Guardian  __/__/____ (REQUIRED FOR STUDENTS UNDER 18 YEARS OF AGE)

MAIL TO: Quinnipiac University  
Student Health Services IR-HLT  
275 Mt. Carmel Ave.  
Hamden, Ct. 06518