Quinnipiac University Student Health Services Requirements

Instructions:

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 MMRs (measles, mumps & rubella), 2 Varicella vaccines – titer results or history of disease; 1 conjugate Meningitis (A,C,Y & W) vaccine – given within 5 years of the first day of class if residing in college-owned housing.

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

3. **Physical Exam Form:** Physical exam **within 2 years**, 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 May 31**. Access through QStart or StudentHealthServices.QU.edu. Please let us know about any health issues, medications and/or allergies you have.

Please submit all forms together. Incomplete forms will be returned!

**Mail to:**
Quinnipiac University
Student Health Services: IR-HLT
275 Mount Carmel Avenue
Hamden, CT 06518-1908
203-582-8742

Please complete form by:
Fall semester - June 30
Spring semester - January 6
Summer semester - May 5

- Your completed forms and online components are required to avoid holds on registration, class grading and housing assignments.
- U.S. mail is the preferred delivery method for all forms. Due to the high volume of paperwork we receive, please allow 2-3 weeks for processing. Please do not call to inquire about the status. We will notify you if your requirements are NOT complete.
- Health science and athletic program requirements are separate from Student Health Services requirements.
**IMMUNIZATION FORM**

**REQUIRED IMMUNIZATIONS**

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Date of Immunization</th>
<th>If given separately or proof of immunity by titer.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meningococcal (A,C,Y,W) conjugate vaccine. Required for students living in college-owned housing</td>
<td><strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></td>
<td>Or Rubeola Titer</td>
</tr>
<tr>
<td>MMR (Measles, Mumps, Rubella) 2 doses required</td>
<td><strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></td>
<td>Or Mumps Titer</td>
</tr>
<tr>
<td>Measles (Rubeola)</td>
<td><strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></td>
<td>Or Rubella Titer</td>
</tr>
<tr>
<td>Mumps</td>
<td><strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></td>
<td>Or Rubella Titer</td>
</tr>
<tr>
<td>Rubella (German Measles)</td>
<td><strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></td>
<td>Or Rubella Titer</td>
</tr>
<tr>
<td>Varicella (Chicken Pox) History of disease, 2 doses required or titer</td>
<td><strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></td>
<td>Or Varicella Titer</td>
</tr>
</tbody>
</table>

**Recommended Immunizations (NOT REQUIRED)**

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Date of Dose #1</th>
<th>Date of Dose #2</th>
<th>Date of Dose #3</th>
<th>Or</th>
<th>Must include copy of titer report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis A 2 Dose Series</td>
<td><strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></td>
<td><strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></td>
<td><strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></td>
<td>Or</td>
<td>Hepatitis A Titer</td>
</tr>
<tr>
<td>Hepatitis B 3 Dose Series</td>
<td><strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></td>
<td><strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></td>
<td><strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></td>
<td>Or</td>
<td>Hepatitis B Titer</td>
</tr>
<tr>
<td>HPV (Gardasil)</td>
<td><strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></td>
<td><strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></td>
<td><strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></td>
<td>Or</td>
<td>Gardasil Titer</td>
</tr>
<tr>
<td>Serogroup B Meningococcal 2 or 3 Dose Series</td>
<td><strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></td>
<td><strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></td>
<td><strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></td>
<td>Or</td>
<td>Meningococcal Titer</td>
</tr>
<tr>
<td>Bexsero 2 Dose Series</td>
<td><strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></td>
<td><strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></td>
<td><strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></td>
<td>Or</td>
<td>Bexsero Titer</td>
</tr>
<tr>
<td>Trumenba 3 Dose Series</td>
<td><strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></td>
<td><strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></td>
<td><strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></td>
<td>Or</td>
<td>Trumenba Titer</td>
</tr>
<tr>
<td>Polio (Most recent Booster)</td>
<td><strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></td>
<td><strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></td>
<td><strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></td>
<td>Or</td>
<td>Polio Titer</td>
</tr>
<tr>
<td>Tetanus-Diphtheria</td>
<td><strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></td>
<td><strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></td>
<td><strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></td>
<td>Or</td>
<td>Tetanus-Diphtheria Titer</td>
</tr>
<tr>
<td>Typhoid</td>
<td><strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></td>
<td><strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></td>
<td><strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></td>
<td>Or</td>
<td>Typhoid Titer</td>
</tr>
</tbody>
</table>

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

Signature of Health Care Provider _________________________________ (MD/DO/PA/NP) provider/facility stamp here

Print or type name _________________________________ Date ______________ Phone Number _______________________________
Part I

TUBERCULOSIS SCREENING FORM

Print name (LAST)_____________________________  (FIRST)__________________________ MI_____  DOB__________

Tuberculosis Screening Questionnaire and Testing Requirements
(Questions 1-3 to be answered by student)

1. Have you ever had a positive PPD or TB Quantiferon test?   YES □ NO □

2. Were you born in, or have you lived, worked or visited for more than one month in any of the following:
   Asia, Africa, South America, Central America or Eastern Europe?   YES □ NO □
   If yes, which country?____________________________  How long?___________________
   Reason (please circle)      Born there        Tourist      Work      School      Other___________________________________

3. Have you had HIV infection, AIDS, diabetes, leukemia, lymphoma or a chronic immune disorder?   YES □ NO □

4. Do any of the following conditions or situations apply to you?
   a. Do you have a persistent (3 weeks or more) cough? Fever, night sweats, fatigue, loss of appetite or weight loss?   YES □ NO □
   b. Have you ever lived with or been in close contact to a person known or suspected of being sick with TB?   YES □ NO □
   c. Have you ever lived, worked or volunteered in any homeless shelter, prison/jail, hospital, drug rehabilitation unit, nursing home or residential health care facility?   YES □ NO □
   If yes, when: _________________________________________________

*If the answer is NO to all the above questions, no further testing is needed. Sign and return form 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.
Part II

TUBERCULOSIS TESTING FORM

Print Name (LAST)_________________________________  (FIRST) __________________________ MI_____  DOB__________

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) OR   TB BLOOD TEST: Lab report must be attached.
Date Planted _____/_____/_____                     Quantiferon                T-Spot
Date Read _____/_____/______      Date _____/_____/_____
Result in induration ____________ mm     Result:       NEG             POS
If no induration, mark “0”

CHEST X-RAY (if skin or blood test is positive)

CHEST X-RAY: Include a copy of chest X-ray
Report. Note: If CXR is more than one year old, must have health care provider complete TB Risk Assessment Questionnaire (available on the Student Health Services website).

University Student Health Services upon arrival to campus.

CHEST X-RAY Date _____/_____/_____     Type of tx ________________________________
Result:        NORMAL             ABNORMAL    Duration____________

MEDICATION TREATMENT

☐ Latent (inactive)
Active TB Disease
Type of tx ________________________________
Duration____________
Treatment completion date _____/_____/_____

Signature of Health Care Provider

______________________________________________________       _ ____________________________________ _
Printed/Typed Name of Health Care Provider

_______________________________________________________
Address (Please print or stamp)

_______________________________________________________
Phone
_______________________________________________________
Fax
_______________________________________________________

Student Health Services: IR-HLT
275 Mount Carmel Avenue.
Hamden, CT 06518-1908
Phone: 203-582-8742
PHYSICAL EXAMINATION FORM

Print Name (LAST) ___________________________  (FIRST) _________________________ MI_____  DOB____________

This section must be completed by a health care provider (within 2 years of enrollment date)

Ht.____________ Wt.____________   BP____________   Pulse____________

CLINICAL EXAMINATION

Check each item in proper column: Enter Normal Abnormal If abnormalities are noted, please describe

NE if not evaluated

Neck
HEENT
Lungs, chest, breast
Heart (include any murmur/defect)
Abdomen (include hernia)
Genitalia
Musculoskeletal/Extremities
Skin
Neurologic
Psychiatric

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

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_____________
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 health care 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 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 Parent or Guardian Date
Signature of Student (Required) Date

MAIL TO: Quinnipiac University
Student Health Services: IR-HLT
275 Mount Carmel Avenue
Hamden, CT 06518-1908

Rev 8/17