UNIVERSITY OF BRIDGEPORT

STUDENT HEALTH SERVICES

STUDENT HEALTH REQUIREMENTS FORM B

**For Students in the School of Professional Studies,**

**Domestic Graduate Students not including Health Sciences**

**PLEASE PRINT ALL INFORMATION:**

STUDENT ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PROGRAM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME PHONE: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL PHONE: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_\_\_\_ BIRTHPLACE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MALE: \_\_\_\_\_ FEMALE: \_\_\_\_\_

**IN CASE OF EMERGENCY:**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME PHONE: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL PHONE: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I hereby grant permission to the Health Services personnel to contact the person named above in the event of a medical emergency.**

STUDENT’S SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**❑ M.M.R. (Measles, Mumps, Rubella)** \*Not required for students born before January 1, 1957

**TWO MEASLES, MUMPS, RUBELLA VACCINES ARE REQUIRED.**

1st Immunization Date: \_\_\_ / \_\_\_ / \_\_\_ (**First** vaccine at or after 12 months of age or 1/1/69.)

2nd Immunization Date: \_\_\_ /\_\_\_ /\_\_\_ (**Second** vaccine required on or after 1/1/80.)

OR

Antibody Titres. (ATTACH LAB SLIP IF TITRE IS BEING USED TO COMPLETE THIS REQUIREMENT.)

**Varicella (Chickenpox)**

** Yes, I was born in the United States before 1980 – NOT REQUIRED.**

** Yes, I was born in the United States after 1980 – REQUIRED**

** No, I was not born in the United States before/after 1980 -  REQUIRED**

1st Immunization Date:   \_\_\_ / \_\_\_ / \_\_\_

2nd Immunization Date:   \_\_\_ /\_\_\_ /\_\_\_   (Given at least 12 weeks after 1st dose for ages 1 – 12 years and at least 4 weeks after 1st dose for ages 13 years and older.)

OR

Antibody Titre. (ATTACH LAB SLIP IF TITRE IS BEING USED TO COMPLETE THIS REQUIREMENT.)

OR

CONFIRMED CASE OF DISEASE by Physician or Public Health Director in student’s present or previous town of residence.

Date of Illness:    \_\_\_ / \_\_\_ / \_\_\_

**Tuberculin/PPD or IGRA REQUIRED WITHIN 6 MONTHS PRIOR TO THE START OF CLASSES.**

**(History of having BCG Vaccine is not considered a contraindication)**

**A TB Risk Assessment (TBRA) indicating “No Risk” can be submitted in lieu of this requirement. The TBRA can be found on** [**www.bridgeport.edu/healthforms**](http://www.bridgeport.edu/healthforms)

PPD: Date Given \_\_\_\_/\_\_\_\_/\_\_\_\_\_PPD: Date Read\_\_\_\_/\_\_\_\_/\_\_\_\_\_ Result \_\_\_\_ mm or IGRA Date\_\_\_\_\_\_\_\_\_\_\_\_ Result\_\_\_\_\_\_\_\_\_\_\_

(MONTH) (DAY) (YEAR) (MONTH) (DAY) (YEAR)

Any History of Positive PPD? (No)\_\_\_ (Yes)\_\_\_ Date:\_\_\_\_\_\_

**If Positive History of PPD or IGRA BOTH QUESTIONS MUST BE ANSWERED. MANDATORY INFORMATION NEEDED:**

1. Prophylactic Treatment Dates: \_\_\_\_\_\_ to \_\_\_\_\_\_ OR Refused Treatment/Prophylaxis (Yes) \_\_\_\_
2. Chest X-ray required if PPD not done if skin test is positive: Chest X-ray Date: \_\_\_/\_\_\_/\_\_\_\_ Result: \_\_\_\_\_\_

**❑Meningitis Vaccination (**On Campus Housing Students Only) within the past 5 years Date: \_\_\_\_/ \_\_\_\_/ \_\_\_\_\_\_

PHYSICIAN NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TELEPHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICIAN SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**STUDENT AUTHORIZATION FOR TREATMENT AT UB HEALTH SERVICES**

**I hereby authorize the University of Bridgeport Student Health Services to provide medical treatment and services as they deem appropriate. This authorization will remain in effect as long as I am a registered student at the University of Bridgeport.**

Student Signature Signature of Parent or Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

(Must be 18 years of age or older) (Student under 18 years of age)

**It is highly recommended that students obtain the health requirements and health records of the vaccines from their primary doctor. Some vaccines are not available in UB Student Health Services and those that are available may be high in cost.**