UNIVERSITY OF BRIDGEPORT
STUDENT HEALTH SERVICES HEALTH FORM A

MANDATORY FOR ALL UNDERGRADUATES, HEALTH SCIENCES STUDENTS, AND INTERNATIONAL STUDENTS

The appropriate health report must be submitted by all students with the exception of distance learning. Registration at the University cannot be confirmed until this form has been accepted as complete by Student Health Services. Parts A and B should be completed by the student prior to being examined by the physician/health care provider.

Entering Semester:  [ ] Fall  [ ] Spring  [ ] Y Y Y Y Status:  [ ] Resident  [ ] Off-campus student

University of Bridgeport Student ID  UB Email  Program

Students joining NCAA teams should fill out the sports form that can be found on bridgeport.edu.

PART A: STUDENT INFORMATION
PLEASE PRINT ALL INFORMATION

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
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<tr>
<th>Cell Phone</th>
<th>Home Phone</th>
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<thead>
<tr>
<th>Birth Date</th>
<th>Birthplace</th>
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<tr>
<td>MM/DD/YYYY</td>
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<table>
<thead>
<tr>
<th>Permanent Home Address</th>
<th>City</th>
<th>State</th>
<th>ZIP Code</th>
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<th>ZIP Code</th>
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<tr>
<th>Marital Status:</th>
<th>Single</th>
<th>Widowed</th>
<th>Married</th>
<th>Divorced</th>
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<thead>
<tr>
<th>Major</th>
<th>Date of entry to U.S.</th>
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<tr>
<th>Varsity Team Sport(s)</th>
<th>Gender:</th>
<th>Male</th>
<th>Female</th>
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<table>
<thead>
<tr>
<th>Mother's Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Phone</th>
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<thead>
<tr>
<th>Father's Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Phone</th>
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<thead>
<tr>
<th>Guardian's Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Phone</th>
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<tr>
<th>Spouse's Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Phone</th>
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IN CASE OF EMERGENCY, NOTIFY:

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Relationship</th>
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<table>
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<th>Address</th>
<th>City</th>
<th>State</th>
<th>ZIP Code</th>
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<thead>
<tr>
<th>Business Phone</th>
<th>Home Phone</th>
<th>Cell Phone</th>
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☐ I hereby grant permission to the Health Services personnel to contact the person named above in the event of a medical emergency.

Student Signature  Date MM/DD/YYYY
Meningitis  Mandatory vaccination within the past 5 years for ALL students who reside in on-campus housing.

Tuberculin/PPD or IGRA  Interferon Gamma Release Assay

Required within six months of registration. History of having BCG vaccine is not considered a contraindication.

<table>
<thead>
<tr>
<th>Immunization Date</th>
<th>Tuberculin/PPD or IGRA</th>
<th>Interferon Gamma Release Assay</th>
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</table>

- **PPD Date Given**
  - M M D D Y Y Y Y

- **PPD Date Read**
  - M M D D Y Y Y Y

- **IGRA Date**
  - D D M M Y Y Y Y

- **IGRA Date**
  - D D M M Y Y Y Y

If positive history of PPD or IGRA, the following information is MANDATORY.

1. Prophylactic treatment dates M M D D Y Y Y Y to M M D D Y Y Y Y

OR Reason for non-treatment

2. Chest x-ray required if PPD not done or if skin test/IGRA is positive. Chest x-ray date M M D D Y Y Y Y

**RECOMMENDED VACCINES**

- Diphtheria/Pertussis/Tetanus DTP
  - 1st Vaccine: M M D D Y Y Y Y
  - 2nd Vaccine: M M D D Y Y Y Y
  - 3rd Vaccine: M M D D Y Y Y Y

- Polio
  - 1st Vaccine: M M D D Y Y Y Y
  - 2nd Vaccine: M M D D Y Y Y Y
  - 3rd Vaccine: M M D D Y Y Y Y

- Hepatitis-B
  - 1st Vaccine: M M D D Y Y Y Y
  - 2nd Vaccine: M M D D Y Y Y Y
  - 3rd Vaccine: M M D D Y Y Y Y

- Hepatitis-A
  - 1st Vaccine: M M D D Y Y Y Y
  - 2nd Vaccine: M M D D Y Y Y Y
  - 3rd Vaccine: M M D D Y Y Y Y

- Hib Vaccine
  - 1st Vaccine: M M D D Y Y Y Y

- HPV Vaccine
  - 1st: M M D D Y Y Y Y
  - 2nd: M M D D Y Y Y Y
  - 3rd: M M D D Y Y Y Y

- Meningitis B
  - 1st: M M D D Y Y Y Y
  - 2nd: M M D D Y Y Y Y
  - 3rd: M M D D Y Y Y Y

- Flu Vaccine
  - M M D D Y Y Y Y

- Other Vaccines
  - M M D D Y Y Y Y
  - M M D D Y Y Y Y
  - M M D D Y Y Y Y

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 may be high in cost.

**PART D: TO THE PHYSICIAN/HEALTH CARE PROVIDER**

This section is to be completed by the physician/health care provider and is mandatory for all students. Please review the student’s history and complete the Health Examination Report. This information will be used only as background for providing health care and will not be released without the student’s consent.

I have examined  Date  M M D D Y Y Y Y

Last Name  First Name  Middle Initial

History of present illness (i.e., asthma, diabetes)

Current or past medical history (i.e., illnesses, surgeries, injuries, psychiatric conditions)

Social history

Indicate location and dates of travel within the past year
MANDATORY INSURANCE COVERAGE

The University of Bridgeport Health Insurance policy is mandatory for all international students, all students in campus housing, students in the Physician Assistant Program, and all full-time undergraduate students. Only domestic students have the option to apply for an insurance waiver. Waivers will only be approved if the domestic student provides documentation of comparable health insurance and a valid insurance card.

PART B: 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 ____________________________  Date M M D D Y Y Y Y
(Must be 18 years of age or older)

Signature of Parent or Guardian ____________________________  Date M M D D Y Y Y Y
(If student is under 18 years of age)

The possibility exists that your student may require emergency hospitalization while at the University. As you know, hospitals require the signature of a parent, a guardian, or a designated agent before administering anesthesia or performing surgery on a minor. If a situation arises requiring such a signature, the University will, of course, make every effort to contact you. In the event that you cannot be contacted in time, however, it might be necessary for an authorized representative from the University to act as your agent. With this in mind, the following statement has been prepared for you to sign, thereby giving the University the authorization to act as your agent.

I hereby authorize and request that you, on my behalf and as my agent, arrange for hospitalization and all medical and surgical services for my child in the event I cannot be contacted in time to sign for such services myself. I hereby waive and relinquish any claim against you consequent upon your exercise of this authority on my behalf.

Signature of Parent or Guardian ____________________________  Date M M D D Y Y Y Y

Following the prompt completion of this medical form, mail, fax, or email a scanned copy to the following address:

University of Bridgeport  Tel: 203.576.4712
Student Health Services  Fax: 203.576.4715
60 Lafayette Street, Room 116  Email: healthservices@bridgeport.edu
Bridgeport, CT 06604

PART C: VACCINE AND TUBERCULOSIS REQUIREMENTS FOR ALL NON-CLINICAL HEALTH SCIENCE PROGRAMS AND PRE-NURSING STUDENTS

This section is to be completed by the physician/health care provider and is mandatory for all students.

The following immunizations and tests are mandatory prior to registration and to reside in on-campus housing.

☐ Meningococcal Vaccine (A, C, Y, W-135) M M D D Y Y Y Y

☐ MMR (Measles, Mumps, Rubella) Not required for students born before January 1, 1957.

Two measles, mumps, and rubella vaccines are required. Both vaccination dates must be listed.

1st Immunization M M D D Y Y Y Y 2nd Immunization M M D D Y Y Y Y
(First vaccine at or after 12 months of age or after 1/1/69) (Second vaccine required on or after 1/1/80)

OR Antibody titer for measles, mumps, and rubella
You must provide proof of immunity with lab slip. Attach lab slip if titer is being used to complete this requirement.


Two varicella vaccines are required. Both vaccination dates must be listed.

1st Immunization M M D D Y Y Y Y 2nd Immunization Date M M D D Y Y Y Y
(Second dose given at least 12 weeks after first dose, if that was given at 1–12 years, or at least 4 weeks after first dose, if that was given at 13 years or older)

OR Antibody titer You must provide proof of immunity with lab slip. Attach lab slip if titer is being used to complete this requirement.

OR Confirmed case of disease by physician/health care provider or public health director in student’s present/previous town of residence.
PART D: TO THE PHYSICIAN/HEALTH CARE PROVIDER (CONTINUED)

Family medical history (i.e., diabetes, hypertension, heart disease, cancer, etc.)

List all allergies (including medication, insect venom, etc.)

Comment on type of reaction (i.e., rash, urticaria, anaphylaxis)

List all medications currently being taken, including vitamins and supplements

If the student has a severe food allergy, please encourage him/her to take a tour of allergy-friendly options on campus by emailing diningservices@bridgeport.edu

Is the student allergic to latex?  □ Yes  □ No

Is an EpiPen prescribed?  □ Yes  □ No

Does the student wear glasses/contacts?  □ Glasses  □ Contacts

Specify reason

Date of last eye exam

PHYSICAL EXAM

Weight

Height

Blood Pressure

Pulse

Temp

Vision (R) (L)

Hearing (R) (L)

General

Skin

Back/Spine

Eye

Contacts

Extremities

HEENT

Genito/Urinary

Vascular

Neurologic

Abdomen

URINALYSIS

Protein  Sugar  Blood  Other

Laboratory Findings

HGB  or HCT

Any other lab results

Status of student’s physical restrictions:  □ Unrestricted  □ Partial restriction  □ Full restriction

Comments

Are there any limitations regarding this student’s participation in school or residing on campus?  □ Yes  □ No

If yes, please specify

Clinical Impression

Recommendations

Physician/Health Care Provider’s Information (please print)

Last Name  First Name  Middle Initial  Telephone

Address  City  State  ZIP Code

Physician/Health Care Provider’s Signature  Date of Exam
SELECT ONE PROGRAM:

- School of Chiropractic
- Fones School of Dental Hygiene
- Medical Lab Science
- Physician Assistant Institute
- School of Naturopathic Medicine
- Acupuncture Institute
- School of Nursing
- Pre-Dental Hygiene

VACCINES REQUIRED

Varicella Vaccine 2 doses OR Positive titer

Lab slip proving immunity must be attached if using titer for this requirement.

```
Dose #1  M M D D Y Y Y
Dose #2  M M D D Y Y Y
```

Measles, Mumps, Rubella, MMR - combined

2 doses OR Positive titer

```
Dose #1  M M D D Y Y Y
Dose #2  M M D D Y Y Y
```

Tetanus, Diphtheria Pertussis (TdaP)

```
Dose #1  M M D D Y Y Y
```

Hepatitis-B Vaccine Series of 3 doses

```
Dose #1  M M D D Y Y Y
Dose #2  M M D D Y Y Y
Dose #3  M M D D Y Y Y
```

Hepatitis-B/Quantitative Titer

MUST ATTACH TITER

Meningococcal Vaccine (A, C, Y, W-135) Required within the past 5 years if living on campus

```
Dose #1  M M D D Y Y Y
Dose #2  M M D D Y Y Y
Dose #3  M M D D Y Y Y
```

RECOMMENDED VACCINES

Hepatitis-A Vaccine

Series of 2 doses (recommended by your health care provider)

```
Dose #1  M M D D Y Y Y
Dose #2  M M D D Y Y Y
```

HPV Vaccine Series of 3 doses

```
Dose #1  M M D D Y Y Y
Dose #2  M M D D Y Y Y
Dose #3  M M D D Y Y Y
```

Meningitis B

```
Dose #1  M M D D Y Y Y
Dose #2  M M D D Y Y Y
Dose #3  M M D D Y Y Y
```

Flu Vaccine

```
Dose #1  M M D D Y Y Y
```

Other Vaccines

Name: ___________________________ M M D D Y Y Y Name: ___________________________ M M D D Y Y Y

Name: ___________________________ M M D D Y Y Y Name: ___________________________ M M D D Y Y Y
**TUBERCULOSIS SCREENING REQUIRED**

Two-Step PPD or IGRA

**PPD Tuberculin skin test (Mantoux)**

Two-step PPD required (one to three weeks apart)

<table>
<thead>
<tr>
<th>Date placed</th>
<th>Date read</th>
<th>Result</th>
<th>mm duration</th>
<th>Positive</th>
<th>Negative</th>
</tr>
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<td>D M D D Y Y Y</td>
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<tr>
<td>PPD #1</td>
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<td>D M D D Y Y Y</td>
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<td>Date placed</td>
<td>Date read</td>
<td>Result</td>
<td>mm duration</td>
<td>Positive</td>
<td>Negative</td>
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<td>Negative</td>
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If PPD is positive at **either reading**, a chest X-ray is required and “Tuberculosis–Statement of Treatment”* must be filled out by the provider.

*Form can be found at [www.bridgeport.edu/healthforms](http://www.bridgeport.edu/healthforms).

**OR**

**Blood Assay for M. tuberculosis (IGRA)**

Provide documentation of a negative IGRA performed within the previous 6 months

<table>
<thead>
<tr>
<th>Date</th>
<th>Result</th>
<th>Positive</th>
<th>Intermediate</th>
<th>Negative</th>
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<tbody>
<tr>
<td>D M D D Y Y Y</td>
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</tbody>
</table>

If IGRA is positive, a chest X-ray is required and “Tuberculosis–Statement of Treatment”* must be filled out by the provider.

*Form can be found at [www.bridgeport.edu/healthforms](http://www.bridgeport.edu/healthforms).

**TO BE COMPLETED BY PHYSICIAN/HEALTH CARE PROVIDER**

Is this student cleared for the full physical and emotional demands of the University of Bridgeport’s graduate or undergraduate programs in Health Sciences or Nursing, including clinical/patient care?

- [ ] Yes/Unlimited activity and fit for program participation
- [ ] No/Limited activity  Reason ____________________________________________________________
  Recommendation ____________________________________________________________

I have reviewed the medical history and examined the student noted above. The information is accurate and complete to the best of my knowledge.

Signature of health care provider ____________________________________________________________

Print name of health care provider ____________________________________________________________

Date M M D D Y Y Y

Phone  Fax

Address  City  State  ZIP Code

Name:  Date of Birth: