Quinnipiac UNIVERSITY

Office of Student Health Services

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.

Quinnipiac UNIVERSITY

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

For Office Use Only
A
PHF
ICM
S
F
L

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

IMMUNIZATION FORM

Last Name _____ First Name _____ MI _____

Date of Birth_____(MM/DD/YY) Student Cell Phone_____

Home Address _____ City _____ State _____ Zip _____

This form requires completion by a health care provider.
Please enter dates in MM/DD/YY format.

REQUIRED IMMUNIZATIONS

Meningococcal (A,C,Y,W) conjugate vaccine. **Required for students living in college-owned housing**	Date of immunization _____/_____/_____ **(Within past 5 years)**			
MMR (Measles, Mumps, Rubella) 2 doses required	Date of Dose #1____/____/____ Given on or after first birthday and after 1/1/1969	Date of Dose #2____/____/____ Given at least 1 month after first dose and after 1/1/1980		
If given separately or proof of immunity by titer.	**Measles (Rubeola)**	Date of Dose #1____/____/____ Given on or after first birthday and after 1/1/1969	Date of Dose #2____/____/____ Given at least 1 month after first dose and after 1/1/1980	Or Rubeola Titer *Must include copy of titer report*
	Mumps	Date of Dose #1____/____/____ Given on or after first birthday and after 1/1/1969	Date of Dose #2____/____/____ Given at least 1 month after first dose and after 1/1/1980	Or Mumps Titer *Must include copy of titer report*
	Rubella (German Measles)	Date of Dose #1____/____/____ Given on or after first birthday and after 1/1/1969	Date of Dose #2____/____/____ Given at least 1 month after first dose and after 1/1/1980	Or Rubella Titer *Must include copy of titer report*
Varicella (Chicken Pox) History of disease, 2 doses required or titer	Date of Dose #1 _____/_____/_____ Given on or after first birthday	Date of Dose #2 _____/_____/_____ Given at least 28 days after first dose	Or Varicella Titer *Must include copy of titer report*	Or History of Disease Date:____/____/___

Recommended Immunizations (NOT REQUIRED)

Hepatitis A 2 Dose Series	Date of Dose #1____/____/____	Date of Dose #2 ____/____/____ Given at least 1 month after first dose		Or Hepatitis A Titer *Must include copy of titer report*
Hepatitis B 3 Dose Series	Date of Dose #1____/____/____	Date of Dose #2 ____/____/____ Given at least 1 month after first dose	Date of Dose #3 ____/____/____ Given at least 6 months after first dose	Or Hepatitis B Titer *Must include copy of titer report*
HPV (Gardasil)	Date of Dose #1____/____/____	Date of Dose #2 ____/____/____ Given at least 1 month after first dose	Date of Dose #3 ____/____/____ Given at least 6 months after first dose	
Serogroup B Meningococcal 2 **or** 3 Dose Series	**Bexsero** 2 Dose Series OR	Date of Dose #1____/____/____	Date of Dose #2 ____/____/____ Given at least 1 month after first dose	
	Trumenba 3 Dose Series	Date of Dose #1____/____/____	Date of Dose #2 ____/____/____ Given at least 2 months after first dose	Date of Dose #3 ____/____/____ Given at least 6 months after first dose
Polio (Most recent Booster)	Date of Booster____/____/____			
Tetanus-Diptheria Booster must be in past 10 years	☐ Td Date _____/_____/_____	☐ Tdap Date_____/_____/_____		
Typhoid	Date _____/_____/_____			

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_____

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

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 <u>NO</u> 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 <u>YES</u> to any of the above questions, TB testing is <u>REQUIRED</u>. Take this form to your health care provider to complete and sign Part II on page 3.**

Quinnipiac UNIVERSITY

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

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

Date Planted _____/_____/_____

Date Read _____/_____/_____

Result in induration _____ mm

If no induration, mark "0"

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. *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 _____/_____/_____

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** _____

_____

Quinnipiac UNIVERSITY

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 NE if not evaluated	Normal	Abnormal	If abnormalities are noted, please describe
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**_____

Quinnipiac
UNIVERSITY

Student Health Services
Consent and Signature Page

Final Checklist:

- ☐ Online Personal Form – **DUE MAY 31** (for fall entry)
- ☐ Immunization Form – Page 1
- ☐ Tuberculosis Screening and Testing Form – Page 2 & 3
- ☐ Physical Exam Form – Page 4
- ☐ Consent and Signature Page – Page 5

Please complete form by:

Fall semester - June 30

Spring semester - January 6

Summer semester - May 5

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 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 Student (Required) **Date**

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

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