University of New Haven

MEDICAL INFORMATION

SAN FRANCISCO, CALIFORNIA

According to Connecticut State Law, all students born after January 1, 1957 and entering an institution of higher education MUST SHOW proof of having received immunizations for Measles, Mumps, Rubella (German Measles) and Varicella (Chicken Pox). **For your own safety and that of your classmates, you will not be permitted to register until the University's Health Services Office receives proof of immunity for its records.** Since students are registered and attending classes at a university "home" base that is in Connecticut, each student shall follow Connecticut immunization laws.

- **Required Vaccines:**
  - ☐ **Valid MMR injections (Measles, Mumps, Rubella) –** two injections are required, or Titre (blood test) proving immunity. Injection must be after January 1, 1969 to be valid. Example: birth date May 15, 1968, first measles injection May 15, 1969 or later. **Injections given before first birthday or prior to January 1, 1969 are not valid.**
  - ☐ **Varicella (Chicken Pox)** – history of disease with date or Titre (blood test) is required to prove immunity. Otherwise, two doses of vaccine.
- **Recommended Vaccines:**
  - ☐ **Hepatitis A vaccine** (2 dose series)
  - ☐ **Hepatitis B vaccine** (3 dose series)
  - ☐ **Gardasil** (HPV vaccine) 3 dose series
  - ☐ **Tuberculosis** testing within the past twelve months.
  - ☐ **Tetanus** – Updated injection within the past 10 years.

If you have received the required vaccines, **please submit proof of immunity**, i.e., records from school, parents' records or **copies of lab results of blood tests** (for Rubella, Mumps, Rubeola, and Varicella titres).

If you have not been immunized, we suggest you contact your family physician as soon as possible.

If you were born prior to January 1, 1957, the vaccine requirement does not apply.

QUESTIONS? Contact the Health Services Office weekdays between the hours of 8:30 a.m. and 4:30 p.m. EST at 203.932.7079, Fax us at 203.931.6090.

MAIL TO: Health Services Office
University of New Haven
300 Boston Post Road
West Haven CT 06516

REV. 3/15 | Produced by Department of Marketing and Enrollment Communications 62369-0315

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It is mandatory that all students entering UNH have a completed Immunization Report on file.

In the past several years, outbreaks of vaccine-preventable diseases on college campuses throughout the United States have resulted in many lost school days, severe complications from the diseases, and anxieties for students, and large expenditures of monies to contain these outbreaks. Compliance by each student with the pre-entrance immunization policy at UNH protects the student and the general college community.

All students are required to complete the Immunization report prior to the beginning of classes in the initial term.

Page 1 should be completed by the student. Page 2 is for the clinician to complete, or attach lab reports.

Entering term: ☐ Fall ☐ Summer ☐ Spring **Year** _____

Status: ☐ Part-time ☐ Full-time

Name Last First Middle Initial

ID # or Social Security #

Birth Date

Birth Place

Home Phone

Cell Phone

☐ Male ☐ Female

☐ Single ☐ Widowed ☐ Married ☐ Divorced

Permanent home address Street

City State Zip

Local address Street

City State Zip

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University of New Haven

MEDICAL INFORMATION

SAN FRANCISCO, CALIFORNIA

IMMUNIZATION RECORD: **Immunity is REQUIRED prior to registration.**

TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER **(Dates must include month and year.)**

Month	Day	Year

NAME: _____

Required:

A. MMR (MEASLES, MUMPS, RUBELLA)

1. ☐ Dose 1 — Immunized at 12 months of age on or after 1/1/69 ..... ____ / ____ / ____
2. ☐ Dose 2 — Immunized on or after 1/1/80 *(according to Connecticut State Law)* ..... ____ / ____ / ____
3. ☐ Has report of immune Titre, specify date of Titre *(send copy)* ..... ____ / ____ / ____

B. VARICELLA (CHICKEN POX)

1. ☐ Hx of Disease ☐ Yes ____ (Year) Titre proof of immunity *(send lab copy)* ..... ____ / ____ / ____
2. ☐ Vaccination: Two required doses: Dose #1 ____ (Month) / ____ (Year) Dose #2 ____ (Month) / ____ (Year)

Recommended:

C. TETANUS-DIPHTHERIA

1. ☐ Completed primary series of tetanus diphtheria immunizations ..... ____ / ____ / ____
2. ☐ Tetanus-diphtheria booster required within the last 10 years ..... ____ / ____ / ____
3. ☐ Tetanus, diphtheria, pertussis ..... ____ / ____ / ____

D. TUBERCULOSIS — CHECK APPROPRIATE BOX

1. ☐ PPD (Mantoux) test within the past year *(Tine or manovac not acceptable)*
   Give date and test results ☐ Positive ☐ Negative ..... ____ / ____ / ____
2. ☐ Positive PPD — Chest x-ray required.
   Give date and result of chest x-ray ☐ Positive ☐ Negative ..... ____ / ____ / ____

E. POLIO

1. ☐ Completed primary series of polio immunizations ..... ____ / ____ / ____
   Type of vaccine: ☐ Oral ☐ Inactivated ☐ E-IPV
   Last Booster: ..... ____ / ____ / ____

F. HEPATITIS B ..... Dose #1 ____ (Month) / ____ (Year) Dose #2 ____ (Month) / ____ (Year) Dose #3 ____ (Month) / ____ (Year)

1. Hepatitis B surface antibody ..... ____ (Month) / ____ (Year) Reactive ____ Non-reactive ____
2. Hepatitis A ..... Dose #1 ____ (Month) / ____ (Year) Dose #2 ____ (Month) / ____ (Year)

G. MENINGITIS VACCINATION ..... ____ (Month) / ____ (Day) / ____ (Year) ☐ Menactra ☐ Other/document name

H. GARDASIL VACCINE (HPV VACCINE) ... Dose #1 ____ (Month) / ____ (Year) Dose #2 ____ (Month) / ____ (Year) Dose #3 ____ (Month) / ____ (Year)

HEALTH CARE PROVIDER (Please print or use stamp)

Print Clinician's Name Last First **Phone Number**

Address Street City State Zip

Clinician's Signature

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