SACRED HEART UNIVERSITY
WELLNESS CENTER
ATTN: HEALTH SERVICES

PART-TIME UNDERGRADUATE STUDENTS

Return completed form to: **Sacred Heart University, Health Services, 5151 Park Avenue, Fairfield, CT 06825**

STUDENT

LAST NAME (Please Print) FIRST NAME M.I. D.O.B. COUNTRY OF BIRTH STUDENT ID NO.

HOME ADDRESS CITY OR TOWN STATE ZIP PHONE E-MAIL ADDRESS

Section MUST be completed by either a physician or nurse.

VACCINE **Born after 1/1/57**	**1st Dose after 1/1/69**	**2nd Dose after 1/1/80**	**Lab Evidence of immunity (only if vaccine dates N/A)** ***Accompanied by Laboratory Report*** **Date of test**	**Result of test**
MMRs or				
Measles Mumps Rubella				

VARICELLA (Chickenpox) **Required by State of CT for Individuals born after January 1, 1980**	**NATURAL DISEASE ____/____ (MTH/YR)** **VACCINE DATE #1____/____/____ #2_____/_____/____ OR** **TITER RESULT _____ DATE ___/____/____** **Accompanied by the Laboratory Report**

Current Medications: _____

Drug Allergies: _____

Other Allergies: _____

Personal Physician Name; _____ _____

Address: _____

Doctor's signature/stamp: _____ **Telephone #** _____

Tuberculosis (TB) RISK QUESTIONNAIRE -

Name	Date of Birth / /	Country of Birth
Street Address		Student ID # ☐☐☐☐☐☐☐☐
City State Zip	Home Phone ( )	Cell Phone ( )
	E-mail Address	

A through D To be answered by the student (TB skin test if necessary)

A. Have you ever had a positive skin or blood test in the past? ***If Yes, please complete chest x-ray section below*** ☐ Yes ☐ No

B. To the best of your knowledge have you ever had close contact with anyone who was sick with Tuberculosis (TB)? ☐ Yes ☐ No

C. Were you born in one of the countries listed below? ***If yes circle country*** ☐ Yes ☐ No

D. Have you ever traveled or lived for more than one month in one or more of those countries listed below? ***If yes circle country*** ☐ Yes ☐ No

Afghanistan	Comoros	Kazakhstan	Niger	Sudan
Algeria	Congo	Kenya	Nigeria	Suriname
Angola	Côte d'Ivoire	Kiribati	Niue	Swaziland
Anguilla	Democratic People's Republic of Korea	Kuwait	Northern Mariana Islands	Syrian Arab Republic
Argentina	Democratic Republic of the Congo	Kyrgyzstan	Pakistan	Taiwan
Armenia	Djibouti	Lao People's Democratic Republic	Palau	Tajikistan
Azerbaijan	Dominican Republic	Latvia	Panama	Thailand
Bahrain	Ecuador	Lesotho	Papua New Guinea	The former Yugoslav Republic of Macedonia
Bangladesh	El Salvador	Liberia	Paraguay	Timor-Leste
Belarus	Equatorial Guinea	Libyan Arab Jamahiriya	Peru	Togo
Belize	Eritrea	Lithuania	Philippines	Trinidad and Tobago
Benin	Estonia	Madagascar	Poland	Tunisia
Bhutan	Ethiopia	Malawi	Portugal	Turkey
Bolivia (Plurinational State of)	Fiji	Malaysia	Qatar	Turkmenistan
Bosnia and Herzegovina	French Polynesia	Maldives	Republic of Korea	Turks and Caicos Islands
Botswana	Gabon	Mali	Republic of Moldova	Tuvalu
Brazil	Gambia	Marshall Islands	Romania	Uganda
Brunei Darussalam	Georgia	Mauritania	Russian Federation	Ukraine
Bulgaria	Ghana	Mauritius	Rwanda	United Republic of Tanzania
Burkina Faso	Guam	Mexico	Saint Vincent and the Grenadines	Uruguay
Burundi	Guatemala	Micronesia (Federated States of)	Sao Tome and Principe	Uzbekistan
Cambodia	Guinea	Mongolia	Senegal	Vanuatu
Cameroon	Guinea-Bissau	Morocco	Serbia	Venezuela (Bolivarian Republic of)
Cape Verde	Guyana	Mozambique	Seychelles	Viet Nam
Central African Republic	Haiti	Myanmar (Burma)	Sierra Leone	Wallis and Futuna Islands
Chad	Honduras	Namibia	Singapore	Yemen
China	India	Nauru	Solomon Islands	Zambia
China, Hong Kong Special Administrative Region	Indonesia	Nepal	Somalia	Zimbabwe
China, Macao Special Administrative Region	Iran	Netherlands Antilles	South Africa	
Colombia	Iraq	New Caledonia	South Sudan	
	Japan	Nicaragua	Sri Lanka	

Prior BCG does not exempt patient from this requirement. If you answered NO to all questions no further action is required. If you answered YES to any of the above questions: ***Sacred Heart University*** requires that a healthcare provider Complete the following TB testing evaluation.

I confirm that the information above is accurate.

Student Signature: **Date:**

TB SKIN TEST Use 5TU Mantoux test only.	**Date Planted:**	**Date Read:**	Interpretation **(if no induration, mark 0)** ☐ NEG ☐ POS mm of induration

CHEST X-RAY **Required within 1 year of the positive TB Skin or blood test.** **X-ray report MUST BE ATTACHED**

Chest X-ray Date: ☐ Normal ☐ Abnormal

TB TREATMENT **MEDICATION (with dose:)**

Frequency:	Start & Completion Dates:

I confirm that the information above is accurate.

Clinician Signature: **Date:**

Address: **Telephone:**

Please mail completed forms to:

Sacred Heart University
Wellness/Health Services
5151 Park Avenue
Fairfield, Connecticut 06825-1000