Sacred Heart UNIVERSITY

Dear New Student,

Welcome to Sacred Heart University! We hope your experience here will be a healthy and happy one.

The State of Connecticut requires that we collect some basic health information before you begin your studies. *All new students, unless you are a distance learner (online classes only), must submit these forms.* It is your responsibility alone to make sure that we have received all the required information – failure to comply with the State requirements will result in your student account being blocked, prohibiting you from registering for classes AND entry into university housing.

Please read the information below carefully and completely and follow all instructions. Feel free to call us with any questions or concerns at 203-371-7838 or email us at healthservices@sacredheart.edu.

A. Checklist: Please use this checklist to assist you in completing the New Student Health Form

- ☐ Print out this form in its entirety.
- ☐ Complete Section I (Tuberculosis High Risk Screening Questionnaire) and sign form in space provided.
- ☐ Bring the form to your healthcare provider and have them fill out Sections II (TB Screening Test, if required), III (Immunization History), and IV (Clinician Information). *The New Student Health Form must be signed, dated and stamped by your healthcare provider*.
- ☐ Scan or take a photo of the completed form (and all supporting documents given to you by your healthcare provider).
- ☐ Log in to your Student Health Portal (https://myhealth.sacredheart.edu) with your SHU username and password and follow all instructions on the home page. You will be required to upload this form to the Portal. DO NOT MAIL, EMAIL OR FAX YOUR FORMS!
- ☐ Await review and verification of your uploaded forms (this can take up to 10 business days), then make sure to check your messages in the Student Health Portal ("Messages" tab) or your SHU email and respond to any requests for further information or corrective action.

All health forms must be submitted by JULY 15TH FOR FALL SEMESTER (or 4 weeks prior to the start of classes for all other start dates)

B. Required Vaccinations/Screening (updated 1/2023)

The following are required by the State of Connecticut and Sacred Heart University:

1. MMR (Measles, Mumps and Rubella) Vaccine: Two doses of each Measles, Mumps and Rubella vaccines (or the combined MMR vaccine) administered at least 28 days apart with the first dose ON or AFTER your first birthday **OR** evidence of immunity to Measles, Mumps and Rubella via blood titers – lab reports are required. Required for all students born after 1956.
2. Varicella (Chicken Pox) Vaccine: Two doses administered at least 28 days apart with the first dose ON or AFTER your first birthday **OR** documentation of date of Varicella disease signed by your healthcare provider **OR** evidence of immunity to Varicella via blood titers – lab reports are required. Required for all students born after 1979.
3. Meningitis ACYW Vaccine: One dose within the past 5 years *only if you will be living in the SHU residence halls.*
4. Tuberculosis (TB) Screening Questionnaire: You must fill out this questionnaire and based on your answers, you may be required to have skin or blood TB testing.

For information on exemptions to the required vaccinations, please see the CT State Department of Public Health website section on Immunization Laws and Regulations: https://portal.ct.gov/DPH/Immunizations/Immunization--Laws-and-Regulations.

C. Recommended Vaccinations

The following vaccines are strongly recommended by Sacred Heart University: COVID-19, Hepatitis A, Hepatitis B, HPV, Meningitis B, and Tdap.

D. Programs Requiring Additional Health Forms

Some students are required to submit additional health forms for their specific program of study or sport. For instance, D1 athletes must submit NCAA health forms to the Athletics Department, Nursing and some health science students must submit "CastleBranch" or "PreCheck" forms to their program, and so on. *Your program will notify you about any additional required health forms*. Even if you have submitted health forms to the Athletics department or your program of study, **you are still required to submit health forms to Student Health Services since we are required by law to collect this information.**

Please continue to page 1 of the New Student Health Form

Sacred Heart University New Student Health Form (Page 1 of 2)

Submit all completed forms and any supporting documents by uploading to the Student Health Portal - https://myhealth.sacredheart.edu

Student Last Name	Student First Name	Student Middle Name
Date of Birth	**Gender Identity** **Sex Assigned at Birth**	**SHU ID#**

Date Beginning School: ☐ **Fall 20_____** ☐ **Spring 20_____** ☐ **Commuter** ☐ **Campus Housing** ☐ **Undergraduate** ☐ **Graduate**

Student's Cell Phone	Student's Preferred E-mail Address

SECTION I: TUBERCULOSIS HIGH RISK SCREENING QUESTIONNAIRE

Student: Please answer questions 1 through 4 then follow instructions below

1. Have you ever had a positive tuberculosis (TB) skin or blood test in the past?	☐ Yes ☐ No
2. To the best of your knowledge, have you ever had close contact with anyone who was sick with TB?	☐ Yes ☐ No
3. Were you born in one of the countries listed below? ***If yes, which country?*** _____	☐ Yes ☐ No
4. Have you spent more than one month in one or more of the countries listed below?	☐ Yes ☐ No

If you answered NO to all questions above, no further testing is required. Please sign below.

If you answered YES to any question above, you must have a TB skin or blood test documented by your healthcare provider (see Step 1). No exemption for prior BCG. Please sign below.

By signing below, I confirm that all the information provided in this form is accurate.

Student Signature	Date
X	

SECTION II: TB SCREENING TEST To be filled out by healthcare provider

TB screening test *only required* if student answers YES to any of the above questions. Healthcare provider must document test results and sign below. All TB skin or blood tests must be done **within 1 year** prior to the start of school.

STEP 1: TB SKIN TEST (PPD)	OR	TB BLOOD TEST/IGRA*	STEP 2: CHEST X-RAY	AND	MEDICATION TREATMENT
Date PPD Planted: _____ **Date PPD Read:** _____ **Interpretation:** ☐ NEG ☐ POS **mm of induration:** _____		☐ Quantiferon ☐ T-Spot **Date:**_____ **Result:** ☐ NEG ☐ POS **preferred with previous BCG. Lab report required.*	**Required only if past or current positive TB skin or blood test. Chest x-ray should be done within one year of the positive skin/blood test. Radiology report must be included.** **Chest X-ray Date:**_____ ☐ Normal ☐ Abnormal		**Medication(s) Used:** **Dates Administered:**

If PPD or IGRA test is Negative, no further testing required.
If test is Positive, proceed to Step 2. ➡

Healthcare Provider Signature	Date	Healthcare Provider Name and Title (print)
X		

List of High Risk Tuberculosis Countries for TB Questionnaire above

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Côte d'Ivoire
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
China, Hong Kong SAR
China, Macao SAR
Colombia
Comoros
Congo
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominica
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Eswatini
Ethiopia
Fiji
French Polynesia
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Malta
Marshall Islands
Mauritania
Mexico
Micronesia (Federated States of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Niue
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Sao Tome and Principe
Senegal
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Tajikistan
Thailand
Timor-Leste
Togo
Tokelau
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2020. Countries with incidence rates of ≥ 20 cases per 100,000 population

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Submit all completed forms and any supporting documents by uploading to the Student Health Portal - https://myhealth.sacredheart.edu

Student Last Name:	Student First Name:	Date of Birth:

SECTION III: IMMUNIZATION HISTORY To be filled out by healthcare provider only; will accept printed vaccine record

MEASLES, MUMPS, RUBELLA (MMR) VACCINATION - Dose #1 on or after first birthday, dose #2 at least 28 days later; Required if born after 1956.

OPTION 1: OR	Measles, Mumps, Rubella (MMR) Vaccination	**Dose #1** MM / DD / YYYY	**Dose #2** MM / DD / YYYY

OPTION 2: OR	Measles Vaccination AND → **Dose #1** MM / DD / YYYY **Dose #2** MM / DD / YYYY	Mumps Vaccination AND → **Dose #1** MM / DD / YYYY **Dose #2** MM / DD / YYYY	Rubella Vaccination **Dose #1** MM / DD / YYYY **Dose #2** MM / DD / YYYY

OPTION 3:

Measles Titer Result: ☐ Immune ☐ Not immune Date _____ MM/DD/YYYY

Mumps Titer Result: ☐ Immune ☐ Not immune Date _____ MM/DD/YYYY ATTACH ALL LAB REPORTS

Rubella Titer Result: ☐ Immune ☐ Not immune Date _____ MM/DD/YYYY

*If not immune, you are required to get 2 MMR vaccines separated by at least 28 days

VARICELLA VACCINATION - Dose #1 on or after first birthday, dose #2 at least 28 days later; Required if born after 1979.

OPTION 1: OR	Varicella Vaccination	**Dose #1** MM / DD / YYYY	**Dose #2** MM / DD / YYYY

OPTION 2: OR

Varicella Titer Result: ☐ Immune ☐ Not immune Date _____ MM/DD/YYYY ATTACH ALL LAB REPORTS

*If not immune, you are required to get 2 Varicella vaccines separated by at least 28 days

OPTION 3:	An incidence of disease will take the place of a vaccine requirement (Must be filled in by a physician/DO/APRN/PA)	Varicella (Chicken Pox) Disease (Date required) MM/DD/YYYY

MENINGOCOCCAL VACCINATION - Required of all students living in University housing

Meningococcal Vaccination **Must cover strains A, C, Y, W-135**	**Date** MM / DD / YYYY	**Vaccination must have been given within 5 years of the first day of classes at SHU.**

RECOMMENDED VACCINATIONS

HEPATITIS A	**Dose #1** MM / DD / YYYY	**Dose #2** MM / DD / YYYY		**TETANUS, DIPHTHERIA, PERTUSSIS** (within the last 10 years)	☐ Tdap ☐ Td	**Date** MM / DD / YYYY
HEPATITIS B	**Dose #1** MM / DD / YYYY	**Dose #2** MM / DD / YYYY	**Dose #3** MM / DD / YYYY	**COVID-19** Please indicate vaccine type given for each dose	**Dose #1** MM / DD / YYYY	**Vaccine type given** _____
HUMAN PAPILLOMAVIRUS (HPV)	☐ HPV4 ☐ HPV9	**Dose #1** MM / DD / YYYY	**Dose #2** MM / DD / YYYY	**Dose #3** MM / DD / YYYY	**Dose #2** MM / DD / YYYY	_____
MENINGOCOCCAL SEROGROUP B	☐ Trumenba ☐ Bexsero	**Dose #1** MM / DD / YYYY	**Dose #2** MM / DD / YYYY	**Dose #3** MM / DD / YYYY	**Dose #3** MM / DD / YYYY	_____

SECTION IV: CLINICIAN INFORMATION To be filled out by healthcare provider

By signing below, I confirm that the above information is accurate to the best of my knowledge and that this student has no medical condition that would prohibit him/her/them from participating fully in all educational activities. This is NOT a clearance for D1 or club sports.

Healthcare Provider Signature **Date** X	**Office Address and Phone #**
Healthcare Provider Name and Title (print)	**Office Stamp**

End of New Student Health Form