Connecticut State University
Central ▪ Eastern ▪ Southern ▪ Western

BR# 89-130

P.O. Box 2008, New Britain, Connecticut 06050
(203) 827-7700

RESOLUTION

requiring

MEDICAL HISTORY FORM

June 16, 1989

WHEREAS, An important underlying foundation for learning is good mental and physical health, and

WHEREAS, The Trustees have provided Health Services at each Connecticut State University campus for our full-time students and emergency services for our part-time students, and

WHEREAS, The State of Connecticut has begun to finalize legislation pertaining to immunization requirements and records, and

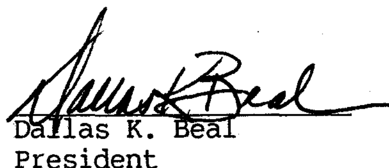
WHEREAS, The Trustees desire to have medical services dispensed to students from a safe, informed and knowledgeable medical basis, now, therefore, be it

RESOLVED, That all full-time students on campuses of the Connecticut State University shall submit a completed medical history on the Medical History Form provided to them prior to registration, and be it

RESOLVED, That part-time students in instances of programmatic needs or of campus medical needs, as determined by the President of the campus, shall submit the required medical records with reasonable dispatch, and be it further

RESOLVED, That any student who is not in compliance with this resolution is subject to dismissal from Connecticut State University.

A Certified True Copy,



Dallas K. Beal
President

An Equal Opportunity Employer

Addendum to BR# 89-130

STATE OF CONNECTICUT

CONNECTICUT STATE UNIVERSITY

MEDICAL HISTORY FORM

TO THE STUDENT: This health record must be completed IN FULL to permit the University Health Service to help you maintain good health. Please fill out this portion of the medical form prior to your physical examination by your physician. This information is strictly confidential. **PLEASE SUBMIT HEALTH RECORD BY THE ACCEPTANCE FEE DEADLINE.**

IDENTIFICATION DATA (Please print clearly)

DATE ____________________

NAME ______________________________________ SOC. SEC. # ____________________
Last First M.I.

PERMANENT HOME ADDRESS ____________________ Street
____________________ City State Zip

HOME TELEPHONE ( ) ____________________
DATE OF BIRTH ____________________
PLACE OF BIRTH ____________________
VARSITY TEAM SPORT ____________________

SEX: ☐ M ☐ F MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

IN CASE OF EMERGENCY NOTIFY:

NAME ____________________ RELATIONSHIP ____________________

ADDRESS ____________________ BUSINESS TELEPHONE ____________________
____________________ HOME TELEPHONE ____________________

PRESENT HOSPITAL/MEDICAL INSURANCE (If different from that offered by CSU)
COMPANY ____________________ POLICY NUMBER ____________________
PARENT'S NAME (If family plan) ____________________ PRESCRIPTION PLAN YES NO (Circle)

CONSENT FOR MINOR (Under 18 years of age)
I give my permission for medical treatment for my daughter/son if accident/illness should occur while she/he is a student at a Connecticut State University campus. This would include referral to a local hospital which may result in her/his hospitalization, anesthesia and surgery should it be necessary and I am unable to be reached.

____________ ______________________________
Date **Parent/Guardian Signature** **Relationship**

PERSONAL HISTORY

*ILLNESSES OR PROBLEMS - Do you have now or have you ever had:

	Yes	No		Yes	No		Yes	No		Yes	No
Chicken Pox	☐	☐	Thyroid Disease	☐	☐	Fractures	☐	☐	Smoker	☐	☐
Whooping Cough	☐	☐	Asthma	☐	☐	Severe Sprain	☐	☐	If yes:		
Tuberculosis	☐	☐	Eczema	☐	☐	Seizure/Epilepsy	☐	☐	# packs/day	☐	
Mononucleosis	☐	☐	Acne	☐	☐	Concussion	☐	☐	# years	☐	
Hepatitis	☐	☐	Heart Disease	☐	☐	Loss Consciousness/Fainting	☐	☐			
Frequent Headaches	☐	☐	Heart Murmur	☐	☐	Colitis/Illeitis	☐	☐			
Migraines	☐	☐	High Blood Pressure	☐	☐	Kidney/Bladder Infections	☐	☐			
Anemia	☐	☐	Rheumatic Fever	☐	☐	Chronic Back Pain	☐	☐			
Diabetes	☐	☐	**Allergies	☐	☐						

** If yes, please list allergy to what: ____________________
* If yes to any of the above, please explain: ____________________

	Y	N	If YES, please explain
Have you ever been hospitalized?			
Operations and /or significant injuries?			
Has your physical activity ever been limited?			
Any physical condition, handicap or learning disability?			
Emotional problems requiring treatment? Medication?			
Have you reacted unfavorably to any medication: penicillin, sulfa,aspirin, tetanus, other?			
Do you wear contact lens? Hearing aids?			
(Women) Do you have or have you had menstrual difficulties that require treatment?			
Any illness or injury not mentioned above?			
List medication you take regularly, including oral contraceptives.			

FAMILY HISTORY

	Age	Health: Good/Poor	Died (age)	Cause of Death	Alcoholism	Allergies	Anemia	Arthritis	Asthma	Bleeding Disorder	Cancer	Diabetes	Eating Disorders*	Epilepsy	Emotional/Mental/Dis.	Genetic Disorder	Heart Attack	Heart Disease	High Blood Pressure	Kidney/Bladder Prob.	Migraine Headache	Neurological Disorder	Suicide or Attempt	Stomach Disease	Stroke**	Tub[illegible]sis
Father																										
Mother																										
Siblings																										
1																										
2																										
3																										
4																										
Over 4																										
Paternal Relatives (#affected in each box)																										
Maternal Relatives (#affected in each box)																										

NOTE: It is important that the University Health Service have knowledge of emotional or psychiatric problems of students entering the University in order that they may be offered the support of the Counseling Service if problems arise.

I certify that to the best of my knowledge the information on this form is complete and correct.

______________________ Date

______________________ Signature of Student

MEDICAL EXAMINATION: REQUIRED WITHIN ONE YEAR PRIOR TO ADMISSION

TO THE PHYSICIAN: Please review the student's history and complete the Medical Examination Form. This information will be used only as a background for providing health care and will not be released without student consent.

I have examined ______________________________ on ______________________________

Name of Student — Date of exam

Height ______ (in.) Weight ______ (lbs.)

VISION: Without Glasses — Right 20/ — Left 20/; With Glasses — Right 20/ — Left 20/

B/P ________
P ________
R ________

HEARING: Right ________________
Left ________________
Method used: ________________

	Normal	Any abnormalities, please explain
Skin		
HEENT Head		
Ears		
Eyes		
Nose/Throat		
Mouth/Teeth/Gingiva		
Neck: Thyroid		
Chest: Breasts		
Lungs		
Heart Rate/Rhythm		
Murmurs		
Abdomen: Liver		
Spleen		
Rectal Exam: Pilonidal		
Hernia		
Genitalia		
Pelvic (if indicated)		
Extremities		
Joints		
Spine		
Neurologic: Sensory		
Cranial Nerves		
Reflexes		
Psychological		

LABORATORY DATA

Required: Hgb. or Hct ______ Urine: S.G. ______ Sugar ______ Protein ______ Micro ______

Optional: VDRL ________ Cholesterol ______________

IMMUNIZATION HISTORY

The following data is required to be up to date.

●Athletes participating in intercollegiate sports may neither practice nor play in games if the following appropriate record is not complete.

●Tetanus required within 10 years.

●Measles, Mumps and Rubella vaccination required; students who received Measles immunization prior to 1969 must be revaccinated.

Primary Series: (List dates)
Polio: 1st ______ 2nd ______ 3rd ______ Booster ________

DPT: ______ Last Booster ______

Tuberculin Mantoux (within one year) ______ (If skin test positive for TB, list date)

Chest Xray: ______ TINE/PPD: ______ (Date) BCG: ______ (Date)

	Vaccine Date	Disease History Date*	Titer/Screen
Measles			
Mumps			
Rubella			

***If disease is not verified by physician or laboratory test, please immunize.**

Is the student on any medication? ________________________________

Does the student have any medical or emotional illness that could affect his/her performance at school? ________

____

The student is in: ☐ excellent ☐ good ☐ poor health.

Recommendation for physical activity: Unrestricted ____ Restricted ____

Please explain *if restricted*: ________________________________

____

Signature ______________________ M.D./D.O. Address ______________________

PRINT Last Name ______________________ Telephone ______________________

TO THE STUDENT: (or from the MD's office with envelope)
Please return to the appropriate campus health service:

CENTRAL CONNECTICUT STATE UNIVERSITY
University Health Service
1615 Stanley Street
New Britain, CT 06050
(203) 827-7375

EASTERN CONNECTICUT STATE UNIVERSITY
University Health Service
One Eastern Road
Willimantic, CT 06226
(203) 456-5263

SOUTHERN CONNECTICUT STATE UNIVERSITY
University Health Service
Wintergreen Avenue
New Haven, CT 06515
(203)397-4457

WESTERN CONNECTICUT STATE UNIVERSITY
University Health Service
105 Berkshire Hall
Danbury, CT 06810
(203) 797-4251