ESL SACRED HEART UNIVERSITY - Immunizations / Vaccination Record

(Students: Return this form to esl@sacredheart.edu)

SECTION I (Completed by Student)

_____

SUR NAME (Please Print) FIRST NAME M.I.

DATE OF BIRTH _____ ___ _____ _____ _____

MONTH XX. DAY XX YEAR. XXXX STUDENT ID#

_____

PERSONAL E-MAIL ADDRESS CELL PHONE

_____

COUNTRY OF CITIZENSHIP PROGRAM OF STUDY

SECTION II (Completed by Physician) **VACCINATIONS REQUIRED BY THE STATE OF CONNECTICUT**

#1 MMR (AFTER YOU TURN 1 YEAR OLD) _____ _____ _____

MONTH XX DAY XX YEAR XXXX

#2 MMR (SECOND IMMUNIZATION) _____ _____ _____

MONTH XX DAY XX YEAR XXXX

OR

TWO DATES FOR EACH ONE (FIRST SET OF DATES AFTER FIRST BIRTHDAY)

#1 MEASLES _____ _____ _____

MONTH XX DAY XX YEAR XXXX

#2 MEASLES _____ _____ _____

MONTH XX DAY XX YEAR XXXX

#1 MUMPS _____ _____ _____

MONTH XX DAY XX YEAR XXXX

#2 MUMPS _____ _____ _____

MONTH XX DAY XX YEAR XXXX

#1 RUBELLA _____ _____ _____

MONTH XX DAY XX YEAR XXXX

#2 RUBELLA _____ _____ _____

MONTH XX DAY XX YEAR XXXX

Student has had chickenpox disease **Yes ___** **MONTH XX _____ YEAR XXXX _____**

No ___ If no please complete the following:

VARICELLA VACCINE DATES

#1 _____ _____ _____

MONTH XX DAY XX YEAR XXXX

#2 _____ _____ _____

MONTH XX DAY XX YEAR XXXX

******TUBERCULIN SKIN TEST MANDATORY MUST BE ADMINISTERED AT SACRED HEART HEALTH SERVICES******

Current Medications: _____

Other Allergies: _____

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

Tuberculosis (TB) RISK QUESTIONNAIRE

Name	Date of Birth	Date
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 you answer, "Yes," Section 6b., "CHEST X-RAY", must be completed ☐ 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
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bahrain
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cambodia
Cameroon
Cape Verde
Central African Republic
Chad
China
China, Hong Kong Special Administrative Region
China, Macao Special Administrative Region
Colombia
Comoros
Congo
Côte d'Ivoire
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
Fiji
French Polynesia
Gabon
Gambia
Georgia
Ghana
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iran
Iraq
Japan
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libyan Arab Jamahiriya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia (Federated States of)
Mongolia
Morocco
Mozambique
Myanmar (Burma)
Namibia
Nauru
Nepal
Netherlands Antilles
New Caledonia
Nicaragua
Niger
Nigeria
Niue
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Saint Vincent and the Grenadines
Sao Tome and Principe
Senegal
Serbia
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Swaziland
Syrian Arab Republic
Taiwan
Tajikistan
Thailand
The former Yugoslav Republic of Macedonia
Timor-Leste
Togo
Trinidad and Tobago
Tunisia
Turkey
Turkmenistan
Turks and Caicos Islands
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Wallis and Futuna Islands
Yemen
Zambia
Zimbabwe

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 B-D 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.

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 for all 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:

Address: **Telephone:**