UNIVERSITY OFBRIDGEPORT
STUDENT HEALTH SERVICES
HEALTH FORM C

For All Nursing Students

The appropriate health report must be submitted by all students with the exception of distance learning. Registration at the university cannot be confirmed until this form has been accepted as complete by Student Health Services.
Entering semester: ___ Fall ___ Spring Year: _____ Status: ___ Resident ____ Off Campus
University of Bridgeport student ID: _____ UB Email: _____ Program: Nursing

PLEASE PRINT ALL INFORMATION

Name:_____Cell Phone(_____)_____
(LAST) (FIRST) (M.I.)
Birth Date:_____/_____/_____Birth Place:_____Home Phone: (_____) _____
(MONTH) (DAY) (YEAR)

Permanent Home Address:_____ ☐ Single ☐ Widowed

City:_____State:_____Zip:_____ ☐ Married ☐ Divorced

Mailing Address:_____City:_____

State:_____Zip:_____Date of entry to US: _____

Varsity Team Sport(s)_____ Gender: : _____
Father's full name:_____Telephone No.: _____
Mother's full name:_____Telephone No.: _____
Guardian's full name:_____Telephone No.: _____
Spouse's full name:_____Telephone No.: _____

IN CASE OF EMERGENCY NOTIFY

Full name:_____Relationship: _____
(LAST) (FIRST)
Address: _____ Business

phone:_____Home phone: _____

I hereby grant permission to the Health Services personnel to contact the person named above in the event of a medical emergency.

Student's signature:_____Date: _____

MANDATORY INSURANCE COVERAGE

The University of Bridgeport Health Insurance policy is mandatory for all international students, all students in campus housing, students in the Physician Assistant Program and all Full Time Undergraduate Students. Only domestic students have the option to apply for an insurance waiver. Waivers will only be approved provided that the domestic student has a description of the comparable health insurance and a valid insurance card.

Name: Date of Birth:

STUDENT AUTHORIZATION FOR TREATMENT AT UB HEALTH SERVICES

I hereby authorize the University of Bridgeport Student Health Services to provide medical treatment and services as they deem appropriate. This authorization will remain in effect as long as I am a registered student at the University of Bridgeport.

Student Signature

_____

(Must be 18 years of age or older)

Signature of Parent or Guardian

_____

(Student under 18 years of age)

Date:_____/_____/ _____
(Month) (Date) (Year)

CONSENT FOR MINORS

The possibility exists that your student may require emergency hospitalization while at the University. As you know, hospitals require the signature of a parent, a guardian or a designated agent before administering anesthesia or performing surgery on a minor. If a situation arises requiring such a signature, the University will, of course, make every effort to contact you. In the event that you cannot be contacted in time, however, it might be necessary for an authorized representative from the University to act as your agent. With this in mind, the following statement has been prepared for you to sign, thereby giving the University the authorization to act as your agent.

I hereby authorize and request that you, on my behalf and as my agent, arrange for hospitalization and all medical and surgical services for my child in the event I cannot be contacted in time to sign for such services myself. I hereby waive and relinquish any claim against you consequent upon your exercise of this authority on my behalf.

Signature of Parent or Guardian

_____

(Student under 18 years of age)

Date:_____/_____/_____
(Month) (Date) (Year)

Following the prompt completion of this medical form, mail, fax or email a scanned copy to the following address:

University of Bridgeport
Student Health Services
60 Lafayette Street Room 116
Bridgeport, CT 06604
Tel: (203) 576-4712
Fax: (203) 576-4715
Email: healthservices@bridgeport.edu

Student's last name:	First:	Middle:	Date of Birth
			_____/_____/_____
			Month Day Year

PHYSICAL EXAMINATION

To be completed by your healthcare provider

Height	Weight	BMI	Blood Pressure	Pulse

Allergies to medications: Yes No *(if yes, list what allergies and specify reaction)*

Severe food allergy: Yes No *(if yes, list what allergies and specify reaction)*If you have a severe food allergy please make arrangements to take a tour of allergy free options on campus by emailing diningservices@bridgeport.edu*

Are you allergic to Latex? Yes No *(if yes, state reaction)*

Is an EpiPen prescribed? Yes No Insect allergy? Yes No Environmental allergy? Yes No

If this student receives allergy immunotherapy complete the Student Allergy Medical Treatment Plan form.

Do you wear glasses / contacts? Yes No Date of last eye exam:

Current or past medical, surgical, or psychiatric condition(s). *List and include relevant medical information.*

_____

_____

Primary medical history. *(diabetes, heart disease, hypertension, asthma, ulcers, TB, cancer, etc.)*

_____

_____

Past surgical history.

_____

Any complications from surgeries. *(anesthesia, bleeding, anaphylaxis, etc.)*

_____

Prescription medication(s): *(list and include dosage)*

_____

_____

Vitamins, supplements and over-the-counter medications taken regularly: *(list)*

_____

Student's last name:	First:	Middle:	Date of Birth
			_____/_____/_____
			Month Day Year

Clinical Evaluation	Normal	Abnormal	Comments
Skin			
Head, ears, eyes, nose, throat, hearing and visual acuity			
Mouth, teeth and gums			
Neck and thyroid			
Lungs / Chest			
Breasts			
Heart (supine and standing)			
Abdomen			
Genitalia			
Back / Spine			
Extremities / Musculoskeletal / Femoral Pulses			
Neurological			
Emotional / Psychological			
Other findings			

Is this student cleared for the full physical and emotional demands of the University of Bridgeport Nursing program, including clinical/patient care?

- ❑ Yes / Unlimited activity and fit for program
- ❑ No / Limited activity Reason:_____

Recommendation:_____

_____

I have reviewed the medical history and examined the student noted above; the information is accurate and complete to the best of my knowledge.

Signature of Healthcare Provider: *(Parent or guardian cannot sign as the healthcare provider.)*		Date:	Phone:
Print Name of Healthcare Provider	Address (include city and state)		Fax

Student's last name:	First:	Middle:	Date of Birth
			_____/_____/_____ Month Day Year

STUDENT VACCINATION RECORD

REQUIRED

Varicella Vaccine 2 doses or positive titer	Dose #1 _____/_____/_____ Month Day Year	Dose #2 _____/_____/_____ Month Day Year	OR ❑ Titer Report Attached OR ❑ History of Disease verified by MD Date_____
Measles, Mumps, Rubella, MMR - combined 2 doses or positive titer. Dose #1 on or after first birthday. Done #2 at least 30 days after 1st dose after 1/1/80.	Dose #1 _____/_____/_____ Month Day Year	Dose #2 _____/_____/_____ Month Day Year	OR ❑ Titer Report Attached
Tetanus, Diptheria Pertussis 1 dose within 10 years	_____/_____/_____ Month Day Year	Select type: ❑ Td ❑ Tdap *(preferred)*	
Hepatitis B / Quantitative Titer	❑ Must attach titer		
Quantitative titer <u>required, in addition to Series</u>			
Hepatitis B Vaccine Series of 3 doses	Dose #1 _____/_____/_____ Month Day Year	Dose #2 _____/_____/_____ Month Day Year	Dose #3 _____/_____/_____ Month Day Year
Meningococcal Vaccine (Required within the past 5 years if living on campus)	_____/_____/_____ Month Day Year		❑ Menactra

OTHER VACCINES

Hepatitis A Vaccine Series of 2 doses (Recommended by your healthcare provider)	Dose #1 _____/_____/_____ Month Day Year	Dose #2 _____/_____/_____ Month Day Year	
HPV Vaccine Series of 3 doses	Dose #1 _____/_____/_____ Month Day Year	Dose #2 _____/_____/_____ Month Day Year	Dose #3 _____/_____/_____ Month Day Year

Clinician Name	Clinician Signature	Date:
Address (include city and state)	Phone:	Fax

Student's last name:	First:	Middle:	Date of Birth
			_____/_____/_____ Month Day Year

TUBERCULOSIS SCREENING (REQUIRED)

PPD Tuberculin skin test (Mantoux)

Provides documentation of a negative PPD done within previous 6 months: **_____Yes** **_____No*** *** two step PPD required (at least 1 week apart)**

PPD#1

Date placed _____/_____/_____ Month Day Year

Date read _____/_____/_____ Month Day Year

Result:_____mm induration
❑ Positive ❑ Negative
If PPD is positive:
❑ Chest x-ray report
❑ Prophylaxis Dates
_____
❑ Prophylaxis not Indicated

PPD#2

Date placed _____/_____/_____ Month Day Year

Date read _____/_____/_____ Month Day Year

Result:_____mm induration
❑ Positive ❑ Negative
If PPD is positive:
❑ Chest x-ray report
❑ Prophylaxis Dates
_____
❑ Prophylaxis not Indicated

OR

Blood Assay for M. tuberculosis
QuantiFERON –TB Gold (QFT-G)

Provides documentation of a negative QFT performed within the previous 6 months.

____Yes
____No

QFT date ___/___/___
Result: ___Negative
___Intermediate
___Positive
If QNF positive:
❑ Chest x-ray report
❑ Prophylaxis Dates
_____
❑ Prophylaxis not Indicated

Clinician Name	**Clinician Signature**	**Date:**