UNIVERSITY OF BRIDGEPORT
STUDENT HEALTH SERVICES
Health Examination Report

HEALTH FORM A

For all Undergraduates, International Students and Health Sciences Students (excluding Nursing)

A completed Health report must submitted by all students with the exception of Distance Learning. If any portion of this form is found to be incomplete, it will be immediately returned to the student by Student Health Services. Registration at the University cannot be confirmed until this form has been accepted as complete by Student Health Services. The physical exam and immunization portion should be completed by the physician. Students joining an NCAA Team should fill in the Intercollegiate Athletics Health Form.

Entering Semester: ❑ Fall ❑ Spring Year: _____ Status: ❑ Resident ❑ Commuter

University of Bridgeport Student ID _____ UB Email_____

STUDENT INFORMATION

PLEASE PRINT ALL INFORMATION

Name: _____Student ID Number_____
(LAST) (FIRST) (M.I.)

Birth Date: _____ / _____ / _____ Birth Place: _____ Home Phone: (_____) _____
(MONTH) (DAY) (YEAR)

Permanent Home Address: _____ ❑ Single ❑ Widowed

City: _____State: _____ Zip: _____ ❑ Married ❑ Divorced

Varsity Team Sport(s) _____ ❑ Male ❑ Female

Father's full name: _____ Father's address: _____

Mother's full name: _____ Mother's address: _____

Guardian's full name: _____ Guardian's address: _____

Spouse's full name: _____ Spouse's address: _____

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, all Full Time Undergraduate Students, and all students in the Physician Assistant Program. 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.

PART B

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) (DAY) (YEAR)

STATEMENT OF AUTHORIZATION FOR HOSPITALIZATION (UNDER 18 YEARS OF AGE)

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

_____

Date:_____/ _____/ _____
(MONTH) (DAY) (YEAR)

Following the prompt completion of this medical form, mail to the following address:

MAIL DIRECTLY TO:

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

TO BE COMPLETED BY THE PHYSICIAN

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

MEDICAL EXAMINATION:
REQUIRED WITHIN ONE YEAR PRIOR TO ADMISSION (TO BE FILLED OUT BY PHYSICIAN ONLY)

I have examined: _____ Date: _____
(LAST) (FIRST) (M.I.) (MONTH) (DAY) (YEAR)

History of Present Illness (i.e., asthma, diabetes): _____
_____

Past Medical History/Surgeries/Injuries/Psychiatric: _____
_____

Social History: _____

Family History (i.e., diabetes/hypertension/heart disease/cancer, etc.): _____
_____

List ALLERGIES (including medication, insect venom, etc.): _____

If you have a food allergy, please contact Dining Services by emailing diningservices@bridgeport.edu to make an appointment to tour the dining facilities and learn about food options that are right for you.

Comment on type of reaction (i.e., rash, urticaria, anaphylaxis): _____

List all MEDICATIONS currently being taken: _____

PHYSICAL EXAMINATION

Weight _____ Blood Pressure _____
Height _____ Pulse _____ Temp. _____
Glasses _____ Vision (R) _____ (L) _____
Contacts _____ Hearing (R) _____ (L) _____
General _____ Back/Spine _____
Skin _____ Extremities _____
HEENT _____ Genito/Urinary _____
Neck _____ Vascular _____
Lungs _____ Lymphatic _____
Heart _____ Neurologic _____
Chest _____ Abdomen _____

URINALYSIS:
Protein _____ Sugar _____ Blood _____ Other: _____
Laboratory Findings: _____
HGB _____ or HCT _____
Any other lab results: _____

Status of Student's Physical restrictions: ❑ Unrestricted ❑ Partial restriction ❑ Full restriction

Comments: _____

Are there any limitations regarding this student's participation in athletics? ❑ Yes ❑ No
If yes, please specify _____
_____

TO BE FILLED BY THE PHYSICIAN

THE FOLLOWING IMMUNIZATIONS WITHIN THE BOLD BLACK BOX ARE MANDATORY BY CONNECTICUT STATE LAW PRIOR TO REGISTRATION AND TO RESIDE IN ON-CAMPUS HOUSING

❑ **M.M.R. (Measles, Mumps, Rubella)** *Not required for students born before January 1, 1957	**Two Measles, Mumps Rubella Vaccines are Required** **BOTH VACCINATION DATES MUST BE LISTED** Immunization Date: ____/ ____/ _____ (**First** vaccine at or after 12 months of age or after 1/1/69) (MONTH) (DAY) (YEAR) Immunization Date: ____/ ____/ _____ (**Second** vaccine required on or after 1/1/80) (MONTH) (DAY) (YEAR) or antibody titers for Measles Mumps and Rubella. You must provide proof of immunity with a lab slip
❑ **Varicella (Chickenpox)** ***Not required for students born in the U.S. before 1980**	**BOTH VACCINATION DATES MUST BE LISTED** First Date: ____/ ____/ _____ (MONTH) (DAY) (YEAR) Second Date: ____/ ____/ _____ (MONTH) (DAY) (YEAR) Given at least 12 weeks after first dose ages 1-12 years and at least 4 weeks after first dose if age is 13 years or older. OR Antibody Titer. You must provide proof of immunity with lab slip. (ATTACH LAB SLIP IF TITER IS BEING USED TO COMPLETE THIS REQUIREMENT) OR Confirmed Case of Disease by a Physician or Public Health Director in student's present or previous town of residence. Date of illness_____
❑ **Meningitis Vaccination (ACY W 135)** Mandatory for ALL students who reside in On campus housing within the past 5 years.	Immunization Date: ____/ ____/ _____

❑ **Tuberculin/PPD or IGRA (Interferon Gamma Release Assay) REQUIRED WITHIN 6 MONTHS OF REGISTRATION**

History of having BCG Vaccine is not considered a contraindication.

PPD: Date Given ____/ ____/ _____ PPD: Date Read ____/ ____/ _____ Result ____ mm or IGRA Date Read ____/ ____/ _____ Result_____
(MONTH) (DAY) (YEAR) (MONTH) (DAY) (YEAR) (MONTH) (DAY) (YEAR)

*A Tuberculosis Risk Assessment indicating "No Risk" can be submitted in lieu of this requirement

Any History of Positive PPD or IGRA? (No)____(Yes)___ Date:_____

If Positive history of PPD or IGRA the following information is mandatory:

1. Prophylactic Treatment Dates: _____ to _____ or Reason for non Treatment_____
2. Chest X- ray Date: ____/ ____/ _____ Result: _____
(MONTH) (DAY) (YEAR)

Other Vaccines

Diphtheria/Pertussis/Tetanus DTP (Initial Series) ____/ ____/ _____ ____/ ____/ _____ ____/ ____/ _____
(MONTH) (DAY) (YEAR) (MONTH) (DAY) (YEAR) (MONTH) (DAY) (YEAR)

Td (adult) booster (within 10 years to date) ____/ ____/_____ *TDAP Recommended.
(MONTH) (DAY) (YEAR)

Polio Initial Series: 1st: ____/ ____/ _____ 2nd: ____/ ____/ _____
(MONTH) (DAY) (YEAR) (MONTH) (DAY) (YEAR)

3rd: ____/ ____/ _____ Booster: ____/ ____/ _____

Hepatitis-B Vaccine Dates: (1) ____/ ____/ _____ (2) ____/ ____/ _____ (3) ____/ ____/ _____ or antibody titre: Date: ____/ ____/ _____
(MONTH) (DAY) (YEAR) (MONTH) (DAY) (YEAR) (MONTH) (DAY) (YEAR) (MONTH) (DAY) (YEAR)

Hepatitis-A Vaccine Dates: (1) ____/ ____/ _____ (2) ____/ ____/ _____ (3) ____/ ____/ _____ or antibody titre: Date: ____/ ____/ _____
(MONTH) (DAY) (YEAR) (MONTH) (DAY) (YEAR) (MONTH) (DAY) (YEAR) (MONTH) (DAY) (YEAR)

H.I.B vaccine Date: ____/ ____/ _____ Other Vaccines and Dates_____

CLINICAL IMPRESSION: _____

Recommendations: _____

Print: Physician's Name _____ Telephone (__) _____

Address: _____

Physician's Signature _____ Date of Examination ____/ ____/ _____

It is highly recommended that students obtain the health requirements and health records of vaccines from their primary doctor. Some vaccines are not available in UB Student Health Services and may be high in cost.