



Certificate of Immunization
Upload to the Student Health Portal
(connc.studenthealthportal.com)
(To be completed by Healthcare Provider)

Student Health Services
270 Mohegan Avenue
New London, CT 06320
Tel: 860-439-2275
Fax: 860-439-5430

Student Name _____ Date of Birth _____
Last First MI

Connecticut State Law requires MMR, Varicella and Meningitis* immunizations to matriculate. Have your Healthcare Provider complete the form or attach your immunization record. Dates are required for immunizations or test results. Please include copies of laboratory reports, if titers done. Enter dates in MM/DD/YYYY format.

* MMR (Measles, Mumps, Rubella) 2 doses required

#1 ___/___/___ (on or after 1st birthday) OR Measles: 1) ___/___/___ 2) ___/___/___
#2 ___/___/___ (at least 28 days after 1st dose) Mumps: 1) ___/___/___ 2) ___/___/___
Rubella: 1) ___/___/___ 2) ___/___/___

OR Measles (Rubeola) Positive titer ___/___/___ Result: _____
Attach/upload copy of laboratory report
Mumps Positive titer ___/___/___ Result: _____
Attach/upload copy of laboratory report
Rubella Positive titer ___/___/___ Result: _____
Attach/upload copy of laboratory report

* Varicella Vaccine 2 doses required

#1 ___/___/___ (on or after 1st birthday) OR History of Chickenpox: Date: ___/___/___
#2 ___/___/___ (at least 28 days after 1st dose) Positive Varicella Titer: Date: ___/___/___
Attach/upload copy of laboratory report

* Meningococcal Conjugate Vaccine (A, C, Y, W): #1 ___/___/___
#2 Booster (within 5 years of entering college): ___/___/___

HIGHLY RECOMMENDED IMMUNIZATIONS - you may include an image of your immunization record

Table with 6 columns: Immunization Name, Date 1, Date 2, Date 3, Date 4, and Notes. Rows include SARS COVID-19, DTP, Hepatitis A, Hepatitis B, HPV (Gardasil), Polio (Most recent Booster), Meningitis B, and Tetanus (Booster must be in past 10 years).

Health Care Provider Signature: _____ MD/DO/NP/PA Phone: _____
Print or Type Name: _____ Date: _____
Provider/Facility Stamp Here

Exemptions: Download and complete:
https://www.conncoll.edu/campus-life/student-health-services/record-requests-and-forms/



Tuberculosis Testing Form

(To be completed by Healthcare Provider)

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Student Name _____ Date of Birth _____

Last First MI

Healthcare Provider should review the information on the Tuberculosis Screening Questionnaire. Students answering "YES" to any of the questions are candidates for tuberculosis (TB) screening with either a Mantoux TB skin test (TST) or an Interferon Gamma Release Assay (IGRA Quantiferon), unless a previous positive test has been documented.

-History of a positive TB skin test or IGRA blood test? (If YES, then document below) YES _____ NO _____
-History of BCG vaccination? (If YES, consider IGRA) YES _____ NO _____

TB SKIN TEST (Mantoux skin test only)

OR

TB BLOOD TEST: Lab report must be attached

Date Planted: ___/___/___

Quantiferon T-Spot

Date Read: ___/___/___

Date: ___/___/___

Result in induration: _____ mm

Result: NEGATIVE POSITIVE

If no induration, mark "0"

INDETERMINATE BORDERLINE (T-spot Only)

Interpretation: NEGATIVE POSITIVE

CHEST X-RAY (Required if TST or IGRA Positive)

Chest X-ray Date: ___/___/___

Chest X-ray Interpretation: NORMAL ABNORMAL

*Include copy of Chest X-ray Report

MANAGEMENT OF POSITIVE TST or IGRA: Please describe treatment plan

Three horizontal lines for describing treatment plan.

Health Care Provider Signature: _____ Date: _____

Health Care Provider Printed Name: _____

Address (Office Stamp): _____ Phone: _____

_____ Fax: _____



Physical Examination Form
(To be completed by Healthcare Provider)

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New London, CT 06320
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Student Name _____ Date of Birth _____
Last First MI

PHYSICAL EXAM: Required of ALL new incoming students. To be completed by your Healthcare Provider.
A physical form signed and dated by a Healthcare Provider within the last 1-2 years will be acceptable.

Please list any significant Past Medical History or any ongoing health conditions:

Medications: Please list current medications and dosages, including birth control and OTC medications:

Allergy to Medication, Food or Other and reaction: (if you have a medical condition that includes severe allergic reactions, you are expected to bring your individual epipen and medication to college):

Surgical History: _____

Height: _____ Weight: _____ BP _____ / _____ Pulse _____

Recommendation for participation in Club, Intramural, or Recreational Sporting Contests:

Unlimited: ___ Limited: ___ If limited, please explain: _____

Table with 4 columns: System, NORMAL, ABNORMAL, Comment on abnormal. Rows include SKIN, HEENT, NECK/THYROID/LYMPH, RESPIRATORY, CARDIOVASCULAR, ABDOMEN (include hernia), GENITOURINARY, MUSCULOSKELETAL, NEUROLOGIC, PSYCHOLOGICAL.

HEALTH CARE PROVIDER:

Signature _____ Date of Exam: _____
Name (or stamp) _____ Phone# _____
Address _____ Fax# _____



CONNECTICUT
COLLEGE

Consent to Treat Minor
(To be completed by Parent/Guardian of Minor)

Student Health Services
270 Mohegan Avenue
New London, CT 06320
Tel: 860-439-2275
Fax: 860-439-5430

Student Name _____ **Date of Birth** _____
Last First MI

I, _____, authorize Connecticut College Student Health Services to provide medical treatment and services, or when circumstances require immediate action, to proceed according to standard medical practices. This consent remains in effect until my student, _____, reaches age 18.

I understand I will be informed, in a timely manner, of any emergency care that is provided or medically indicated.

Parent/Guardian Signature

Date