Welcome to the University of Hartford!

This University of Hartford Health Form is mandatory and the only form that will be accepted as proof of vaccination. All information must be entered on this form. Entering or stamping “See Attached” may delay the processing of your form. Please make this clear to your healthcare provider’s office when you drop off the form. *(A physical is not required)*

All students, including transfer, international and those changing from part-time to full-time status, are required to submit this form to Health Services no later than July 15th for the fall semester and December 15th for the spring semester.

Transfer Students: Your health records are not automatically transferred with your academic records from your prior university. You must submit a completed form with all required information as if you were a first time college student.

Failure to provide documentation will block your ability to register, add or drop classes or move into any campus housing.

*Please return the completed forms to Student Health Services only*
*Do not send to other departments or with any other paperwork.*

If you encounter any difficulty in getting the required information or you have any questions, please contact our office by phone at 860-768-6601.

Please visit our website at: [www.hartford.edu/student_affairs/departments/health_services](http://www.hartford.edu/student_affairs/departments/health_services) for more information on the services we offer.

*Congratulations on your admission to The University of Hartford!*

Mary Norris, Administrative Director
norris@hartford.edu
Name:  
Date of Birth:  
Student ID:  
Cellphone:  
Gender:  
Date Entering University:  
Status:  
Full-Time  
Part-Time  
Permanent Home Information:  
Home Phone:  
Notify in Case of Emergency:  
(Relationship)  
Name:  
Street:  
Phone:  
City:  
Name:  
State/Country  
Zip:  
Phone:  

University email:  

State of Connecticut and The University of Hartford REQUIRE:  
Two doses of MMR (Measles, Mumps, Rubella) & two doses of Varicella  
One dose of Meningitis*  

| MMR #1 | Date: | Pos | Neg |  
| MMR #2 | Date: |  
| Varicella #1 | Date: | Pos | Neg |  
| Varicella #2 | Date: | OR Incidence of disease Chicken Pox | Provider initials: |  

MMR exemption if born prior to 12/31/1956  
Varicella is required only for students born on or after January 1, 1980  

Meningococcal Vaccine (MCV4) is required for all students living in campus housing. (It is strongly recommended for all students)  
Vaccine must be within 5 years of entry. The vaccine is no longer effective after 5 years and a booster may be required.  

Date:  
I will not be living in campus housing  

Other Vaccine History:  
(Tetanus Booster within last 10 years and Hepatitis B series are recommended)  

| Hepatitis B #1 | Date:  |
| Hepatitis B #2 | Date:  |
| Hepatitis B #3 | Date:  |
| Last Tetanus:  
Td  
Date:  |
| HPV: Date #1  
HPV: Date #2  
HPV: Date #3 | Date:  |
| Other Vaccination: | Date:  |
| Date of last Physical: |  

I confirm that the information above is accurate. (must be signed and stamped by Healthcare Provider)  

Clinician Name:  
Signature:  
Date:  
Address:  
City:  
State:  
Zip:  
Phone:  
Fax:  

Consent for treatment required to be signed (if you are less than 18 years of age, signatures of both the student and one parent/guardian are required)  
Student Signature:  
Date:  
Signature of Parent/Guardian:  
Date:  
Student Name:  
Student ID:  

**Personal Medical History:** Please check all that apply

<table>
<thead>
<tr>
<th>Condition</th>
<th>Condition</th>
<th>Condition</th>
<th>Condition</th>
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</thead>
<tbody>
<tr>
<td>Acne</td>
<td>Cerebral Palsy</td>
<td>High Cholesterol</td>
<td>Skin disorder</td>
</tr>
<tr>
<td>Alcohol/drug use</td>
<td>Chronic Bronchitis</td>
<td>HIV/AIDS</td>
<td>Tobacco user</td>
</tr>
<tr>
<td>Anemia</td>
<td>Depression</td>
<td>Insomnia/Sleep prob</td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>Diabetes Type I</td>
<td>Kidney stones/disease</td>
<td>Other:</td>
</tr>
<tr>
<td>Arthritis</td>
<td>Eating disorder</td>
<td>Menstrual Problems</td>
<td></td>
</tr>
<tr>
<td>Bleeding trait</td>
<td>Hay fever/Allergies</td>
<td>Migraine/Headaches</td>
<td></td>
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<tr>
<td>Bipolar</td>
<td>Hepatitis</td>
<td>Phlebitis</td>
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<tr>
<td>Breast disease</td>
<td>Heart disease</td>
<td>Rheumatic fever</td>
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<tr>
<td>Cancer</td>
<td></td>
<td>Seizure disorder</td>
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</tbody>
</table>

**Allergies:**

**Drug and other Severe Adverse Reactions:** Are any life threatening? Yes No
Do you carry an Epi Pen? Yes No

**Prior Hospitalizations or Surgeries—Please list dates and reasons**

**Medications—Frequent or regular. Please list all prescriptions, natural and over the counter medications.**

**Current Medical History/Conditions that we should know about?**

**Insurance Information:** Name of Carrier:

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<thead>
<tr>
<th>Policy #:</th>
<th>Group #:</th>
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</thead>
<tbody>
<tr>
<td>Policy Holder:</td>
<td>Policy Holder’s DOB:</td>
</tr>
<tr>
<td>RX#:</td>
<td>Bin:</td>
</tr>
</tbody>
</table>

**Parent/Guardian: Please note we cannot discuss any health information with you without the student’s written consent if they are 18 or over. The consent must be completed in our office at the time of the visit. The student has a right to refuse. Thank you for your understanding.**

**All forms must be turned into Health Services by the due date on the cover letter in order to move in and or start classes. You will NOT be able to move into campus housing and/or start classes unless fully compliant.**