交换或录取国际学生的健康要求

下面是*《康涅狄格州立大学学生健康服务单》*。请填写表单正反两面。首页需完整填写。如果您在康涅狄格州立大学（CCSU）期间需寻求医疗护理服务，第二页将有助于我们为您提供的服务。请注意，大学健康服务部门不接受免疫表复印件。*《康涅狄格州立大学学生健康服务单》*是唯一可作为免疫证明接的表单。请在送交表格时向您的医疗服务提供者说明。

1) **要求免疫（详情请参见下页）：**康涅狄格州法律及 CCSU 要求所有录取的学生提供针对下列疾病的相关免疫证明：
   - **a. 麻疹、腮腺炎、风疹（MMR）；和**
   - **b. 水痘；**

   居住在学生宿舍的学生必须接受细菌性**脑膜炎**的免疫接种。在美国要求该疫苗为具有 A、C、Y、W 135 亚型细菌的疫苗，这些亚型在贵国不一定存在。您在入住宿舍前必须要对所有四种亚型进行接种。有关脑膜炎预防的更多信息，请见我们的主页 www.ccsu.edu/health 的“Important Medical Update（重要医学更新）”中的 Meningococcal vaccination update（脑膜炎免疫接种）。我们还建议所有学生在过去的 10 年内进行完全的乙型肝炎免疫接种，并接受过破伤风加强注射。

2) **肺结核筛查：**CCSU 同时要求完成**肺结核（TB）风险评估**。请仔细阅读肺结核（TB）风险评估，因为您可能需要进行肺结核筛查检测（皮试或血液检测）。如需完成此类检测，**您必须在进入康涅狄格州立大学后 6 个月内在美国的医疗机构完成此类测试。**
3) **体检报告：该表必须由医疗服务提供者签字。**

大学健康服务部门提供肺结核检测，麻疹、腮腺炎、风疹、水痘和细菌性脑膜炎接种。其它免疫在我们办公室内提供。检测和接种费用将计入您的大学帐户。

请尽可能快地提供大学健康服务部门所需的所有信息，不得迟于在到达学校前两个星期。我们也可能需要其它医疗信息。我们将给您发送电子邮件，使您能在自己国家获得该医疗信息。

如果您未满足这些健康要求或正确填写本表单，您可能无法注册班级，更改日程安排或入住学生宿舍。我们将确保此类事件不会发生。如有任何疑问请拨打 860-832-1925 联系我们。

健康保险注意事项
所有康涅狄格州立中央大学的学生均需参加符合或超出大学提供的 Aetna 学生健康保险范围的健康保险。尽管您可以提供其它健康保险证明以放弃本保险，但请注意，学校周围区域的许多医疗保健提供者（医生和医疗机构）可能拒绝您的替代健康保险，此时您个人将承担医疗费用，甚至无法得到诊治（即使您在看病时能够支付费用）。因此，国际教育中心和大学健康服务部门强烈推荐所有国际学生购买通过大学提供的 Aetna 学生健康保险。有关健康保险的详情，请访问我们的网站 www.ccsu.edu/health。

大学健康服务部门的目的是为了帮助您成功完成您的学习之旅。如果您在获取需要的信息时遇到任何困难或者有任何疑问，请致电（860）832-1925。我们在此会尽一切所能，让您尽早适应在康涅狄格州立大学的生活。有关我们提供的服务的更多信息，请浏览我们的网页，www.ccsu.edu/health。

祝贺您被 CCSU 录取！

大学健康服务部门
医务部主任 Christopher Diamond
APRN 副主任 Marisol Aponte

免疫要求和豁免

康涅狄格州普通成文法和 CCSU 要求所有录取的学生应做到下列各项：

麻疹免疫证明：下列证明，您必须提供以下一种：

- 两份麻疹或两份 MMR 免疫证明（一份为一岁生日之后的，另一份至少为一个月之后的）；**或**
- 实验室结果显示为阳性的麻疹滴定（血液检测）

风疹免疫证明：下列证明，您必须提供以下一种：

- 两份风疹或两份 MMR 免疫证明（一份为一岁生日之后的，另一份至少为一个月后的）；**或**
- 实验室结果显示为阳性的风疹滴定（血液检测）

腮腺炎免疫证明：下列证明，您必须提供以下一种：

- 两份腮腺炎或两份 MMR 免疫证明（一份为一岁生日之后，另一份至少为一个月后的）；**或**
- 实验室结果显示为阳性的腮腺炎滴定（血液检测）

水痘免疫证明：下列证明，您必须提供以下一种：

- 两份水痘免疫证明；**或**
- 实验室结果显示为阳性的水痘滴定（血液检测）

*你也可提交由执证医疗保健提供者开具的麻疹、腮腺炎、风疹和水痘确诊案例证明，以替代上述**证明**。*

所有住宿学生在房间分配前必须提供细菌性**脑膜炎**接种（脑膜炎疫苗）证明。没有此疫苗证明，任何学生不得入住校园。我们强烈建议所有学生注射预防这一疾病的疫苗。如果免疫时间已超过 5 年，请洽寻您的医疗服务提供者并进行加强接种。

乙型肝炎：美国大学健康协会、康涅狄格州公共卫生部和疾病控制中心建议学生进行**乙型肝炎**免疫（*非必须*）。

破伤风：建议每十年进行一次加强接种。

免疫豁免

- 1957 年 1 月 1 日前出生的学生因年龄关系可免除麻疹、腮腺炎和风疹的免疫要求。
- 1980 年 1 月 1 日前出生的学生因年龄关系可免除水痘的免疫要求。
- 因宗教或医疗原因可免除接种，请参见 www.ccsu.edu/health/forms。
  因医疗或宗教原因而免于接种的个人在该要求进行免疫的疾病爆发时不得进入校园。
- 在线学习人员无需满足免疫要求。

Connecticut State University Student Health Services Form

Date Beginning School ☐Fall ☐ Spring of _____

FOR OFFICE USE ONLY
☐ Complete ☐ Missing: _____

PLEASE RETAIN A COPY OF THIS HEALTH FORM FOR YOUR RECORDS BOTH SIDES/PAGES OF THIS FORM MUST BE SUBMITTED

Last Name	First Name	MI

Date of Birth and Birthplace:	Sex/Gender:	**Student ID #:** ☐☐☐☐☐☐☐☐☐

State of Connecticut and Connecticut State Universities REQUIRE:

Two doses for each Measles, Mumps, Rubella & Varicella One dose of Meningitis* Complete TB Risk and/or Test or Treatment

	Vaccine & Date Given	***OR***	Incidence of Disease	***OR***	Titer Test Results (attach lab report)	Requirements
1	Measles #1 ☐ or MMR ☐ Date		Date:		Measles Titer Date :	***Must be*** on or after 1st birthday.
	Measles #2 ☐ or MMR ☐ Date:				Result ☐Pos ☐ Neg	***Must be*** at least 28 days after 1st immunization.
2	Mumps #1 ☐ or MMR ☐ Date:		Date		Mumps Titer Date:	***Must be*** on or after 1st birthday.
	Mumps #2 ☐ or MMR ☐ Date:				Result ☐Pos ☐ Neg	***Must be*** at least 28 days after 1st immunization.
3	Rubella #1 ☐ or MMR ☐ Date:		Date		Rubella Titer Date:	***Must be*** on or after 1st birthday.
	Rubella #2 ☐ or MMR ☐ Date:				Result ☐Pos ☐ Neg	***Must be*** at least 28 days after 1st immunization.
4	Varicella #1 ☐ Date: Varicella #2 ☐ Date:	***OR***	Incidence of Disease Chicken Pox Date: Provider Initials:	***OR***	Varicella Titer Date: Result ☐Pos ☐ Neg	Varicella is required only for students born on or after January 1, 1980 #1 Must be on or after 1st birthday; #2 Must be at least 28 days after 1st immunization
5	Meningococcal ☐ Vaccine Type or Brand: Date :				*Required only if living in university owned housing. ☐ I will not be living in University owned housing. I do not require this vaccine.	

6 TUBERCULOSIS (TB) RISK QUESTIONNAIRE - A through D To be answered by the Student

A. Have you ever had a positive tuberculosis 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 traveled or lived for more than one month in one or more of the countries listed below? ***If yes circle country***.	☐ Yes ☐ No

Afghanistan, Algeria, Angola, Armenia, Azerbaijan, Bangladesh, Belarus, Benin, Bhutan, Bolivia, Bosnia & Herzegovina, Botswana, Brunei Darussalam, Burkina Faso, Burundi, Cambodia, Cameroon, Cape Verde, Central African Republic, Chad, China,China-Macao, China-Hong Kong, Congo, Congo DR, Cote d'Ivoire, Djibouti, Dominican Rep., Ecuador, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Georgia, Ghana, Guatemala, Guinea, Guinea-Bissau, Guyana, Haiti, Honduras, India, Indonesia, Iraq, Kazakhstan, Kenya, Kiribati, Korea-DPR, Korea-Rep, Kyrgyzstan, Lao PDR, Latvia, Lesotho, Liberia, Lithuania, TFYR, Madagascar, Malawi, Malaysia, Mali, Marshall Islands, Mauritania, Micronesia, Moldova-Rep, Mongolia, Morocco, Mozambique, Myanmar, Namibia, Nepal, Niger, Nigeria, Northern Mariana Islands, Pakistan, Papua New Guinea, Paraguay, Palau, Peru, Philippines, Qatar, Romania, Russian Federation, Rwanda, Sao Tome & Principe, Senegal, Sierra Leone, Solomon Islands, Somalia, South Africa, Sri Lanka, Sudan, Suriname, Swaziland, Taiwan, Tajikistan, Tanzania-UR, Thailand, Timor-Leste, Togo, Turkmenistan, Tuvalu, Uganda, Ukraine, Uzbekistan, Vanuatu, Vietnam, Yemen, Zambia, Zimbabwe Based on WHO Global TB Report 2009

6. IF you answer **NO** to all questions no further action is required. **Prior BCG does not exempt patient from this requirement.**

IF you answer **YES** to B-D of the above questions, Connecticut State University requires **that a healthcare provider** complete the following TB testing evaluation and x-ray ***within 6 months prior to the start of classes.*** (After February for Fall Semester and after July for Spring Semester.)

6a. TB BLOOD TEST **OR**	6a. TB SKIN TEST **Use 5TU Mantoux test only.** **TB skin tests ARE NOT ACCEPTED from other countries.**		6b. CHEST X-RAY **Required within 6 months for past or current positive TB skin or blood test.** **X-ray report *MUST BE ATTACHED***	6c. TB TREATMENT **MEDICATION (with dose):**
☐ Interferon-gamma release assay Date: Result: ☐ NEG ☐ POS	**Date Planted:** **Date Read:**	Interpretation (**If no induration, mark 0**) ☐ NEG ☐ POS _____mm of induration	**Chest X-ray Date:** ☐ Normal ☐ Abnormal	Frequency: Start & Completion Dates:

Other Vaccination 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	Hepatitis Titer Date Result: ☐ POS ☐ NEG
Last Tetanus Booster: Td ☐ or Tdap ☐ Date:	Other Vaccination:	Other Vaccination:	Other Vaccination:

Signatures

I confirm that the information above is accurate.

Clinician Signature: **Date:**

Physical Examination Affirmation: **I have examined this patient on _____ and find no medical condition that would prohibit him/her from participating fully in all activities including physical education, trying out for competitive sports or military training and employment.**

Clinician Signature: **Date:**

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)**

I hereby grant permission for the Connecticut State University Health Services staff to provide me with appropriate medical and mental health treatment including medications for treatment of illnesses/injuries and to arrange for any emergency medical care if circumstances at that time make it impossible for me to make such decisions. Furthermore, I understand that University Health Services staff may disclose my student medical records and/or information from such records to appropriate University personnel and/or Emergency Contacts identified within my records in the event of a health or safety situation as determined by the Student Health Services staff.

Signature of Student **Signature of Parent/Guardian** **Date:**

Continue to Page 2 →

Connecticut State University Student Health Services Form

Page 2

PLEASE RETAIN A COPY OF THIS HEALTH FORM FOR YOUR RECORDS BOTH SIDES/PAGES OF THIS FORM MUST BE SUBMITTED

Student Name	Home/Personal Email Address	Student Cell Phone

Permanent Home Information		**Notify in Case of Emergency**	
Home Phone	Cell/Work Phone	Name	Relationship
Street Address		Home Phone	Cell/Work Phone
City	State Zip	Street Address City	State Zip

Personal Physician/Healthcare Provider	
Name:	Address: Telephone #: FAX #

***Personal Medical History*- Please circle all below that apply to you**

☐ **Check here if none apply**

Alcohol/drug Abuse	Diabetes	Mumps
Anxiety/depression/mental illness	Endometriosis	Rheumatic Fever
Asthma	Gastrointestinal Problems	Seizures
Cancer	Hepatitis B or C Disease	Sickle Cell Anemia
Cardiac Condition/Heart Murmur	High Blood Pressure	Thyroid Disorder
Coagulation Disorder	HIV/AIDS	Tuberculosis
Concussion	Measles	Other please explain
Dental Problems	Mononucleosis	

***Allergies: Drugs & Other Severe Adverse Reactions* - Please complete all that apply and explain reaction**

☐ **Check here if you have no allergies**

Medication	Food
Insect	Environmental
Seasonal	X-ray Contrast
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

Is there any other medical information or health concern that we should know about? Please attach any additional information to further explain your condition or concern.

Current Height**: Current Weight**: Last Blood Pressure (if known)**:

****not required**

Did you sign the Consent for Treatment on Page 1?

Please return by mail or fax to the appropriate Health Service listed below.

Central Connecticut State University
University Health Service
1615 Stanley Street
New Britain, CT 06050
860/832-1925 Fax 860/832-2579

Eastern Connecticut State University
University Health Service
185 Birch Street
Willimantic, CT 06226
860/465-5263 Fax 860/465-4560

Southern Connecticut State University
University Health Service
501 Crescent Street
New Haven, CT 06515
203/392-6300 Fax 203/392-6301

Western Connecticut State University
University Health Service
181White Street
Danbury, CT 06810
203/837-8594 Fax 203/837-8583