University of Bridgeport Student Health Services
60 Lafayette Street, Bridgeport CT 06604
Tel: 203-576-4712 Fax: 203-576-4715

Upload to the Student Health Portal
(To be completed by Healthcare Provider)

Student Name _____ Date of Birth___/___/____ Student ID#_____
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: _____
Include copy of laboratory report

Mumps Positive titer____/____/_____ Result: _____
Include copy of laboratory report

Rubella Positive titer____/____/_____ Result: _____
Include copy of laboratory report

***Varicella Vaccine 2 doses required**

#1____/____/_____ (*on or after 1st birthday*) **OR** **History of Chickenpox**: Date: ____/____/_____
#2____/____/_____ (*or at least 28 days after 1st dose*) **Positive Varicella Titer**: Date: ____/____/_____

***Meningococcal Conjugate Vaccine (A,C,Y,W) On Campus Students Only** Date:_____

RECOMMENDED IMMUNIZATIONS – you may include an image of your immunization record

DTP	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Hepatitis A						**Or Hep A titer**
Hepatitis B						**Or Hep B titer**
HPV (Gardasil)						
Polio *Most recent booster*						
Meningitis B						**Indicate if Bexsero or Trumenba**
Tetanus *Booster must be in past 10 years*	**Td** ___/___/___	**Tdap** ___/___/___				

Exemptions: Download and complete **State of Connecticut Medical Exemption Form. Per CT State Law, Non-Medical Exemptions will not be considered.**

Tuberculosis screening, PPD or IGRA for all international students is required within 6 months of registration.
PPD Date Given ____/____/_____ PPD Date Read ____/____/_____ Result _____MM
IGRA Date ____/____/_____ Result _____ (***Attach/upload copy of laboratory report***)
Any history of positive PPD? Y/N Date ____/____/_____

***OFFICE STAMP*:**

Health Care Provider (if immunization record is not attached)

Signature:_____ MD/DP/NP/PA

Print or Type Name:_____ Date:_____ Phone Number:_____ *Revised 4/3/25 GG*