UCONN | UNIVERSITY OF CONNECTICUT

Non-Responder Form for Student Clinical Placement or Other Experiential Learning Experience

Please print:

LAST NAME	FIRST NAME	MI	Date of Birth ____/_____/_______
PeopleSoft ID #	Email @uconn.edu	Cell or Local Phone	
Program ☐ Allied Health Sciences ☐ Nursing ☐ Pharmacy ☐ Physical Therapy ☐ Psychology ☐ Social Work ☐ Speech & Hearing		CAMPUS ☐ Avery Point ☐ Hartford ☐ Stamford ☐ Storrs ☐ Waterbury	

To be completed by Provider (Physician [MD or DO], Physician Assistant, or Nurse Practitioner)

For the checked immunization(s) below, I certify that I have reviewed the medical documentation, immunization history, and laboratory titers, and in my judgment, there is no reason to revaccinate this individual.

- ☐ **Mumps** - Mumps IgG antibody titer negative after repeat vaccination series or history of disease
- ☐ **Rubeola –** Measles (Rubeola) IgG antibody titer negative after repeat vaccination series or history of disease
- ☐ **Rubella** – Rubella IgG antibody titer negative after repeat vaccination series or history of disease
- ☐ **Varicella** (Chicken Pox) – VC IgG Antibody titer negative after repeat vaccination series or history of varicella or herpes zoster (shingles)
- ☐ **Hepatitis B** – Hep B Surface Antibody (HBsAb) titer negative after repeat vaccination series

Provider: By signing this non-responder form for the student named above, I verify that I have counseled the student regarding his/her non-responder status including the opportunity of revaccination (if applicable), susceptibility to the disease(s), precautions to minimize exposure, and the need for medical evaluation if exposure were to occur for the infectious disease checked above.

SIGNATURE OF HEALTH CARE PRACTITIONER **(MD / DO / APRN / PA)** *(Please circle one)*

CLINICIAN SIGNATURE: ____ DATE: ____/_____/_______ PHONE: _(______) ______-_________

CLINICIAN NAME (PLEASE PRINT) ________________________________ ADDRESS: ____

To be completed by Student (Please read the following information carefully and check all that apply)

___ **For MMR/Varicella:** I understand that because of my immune status, I will not be allowed to provide direct care for patients with known active infections of the disease to which I am not immune. If it is discovered that I have been exposed to an active infection of the disease to which I am not immune, I understand that I will not be able to attend clinical until I have provided negative serological results after the contagious phase of the incubation period for the disease.

____ **For Hepatitis B:** I understand that avoiding exposure to blood is the primary way to prevent transmission of blood-borne diseases such as Hepatitis B. Methods to minimize risk of such exposure comprise proper use of personal protective equipment (PPE), observance of aseptic technique, use of sterile, single-use, disposable needle and syringes, prompt and proper disposal of sharps via sharps containers, etc. I understand that if exposed to blood or body fluid that is positive for hepatitis B surface antigen, or to blood or body fluids from a person whose HBsAg status is unknown (via needle stick, for example), that I should immediately seek medical care so that I may be treated with Hepatitis B immune globulin (HBIG) post- exposure prophylaxis in order to minimize risk of disease.

SIGNATURE OF STUDENT*)*

SIGNATURE: ____ DATE: ____/_____/_______