Name _____ DOB_____ PeopleSoft # _____ Program _____

UNIVERSITY OF CONNECTICUT – CLINICAL STUDENT HEALTH RECORDS PACKET

Healthcare professionals have an obligation to ensure patient safety—and that begins by ensuring your own personal safety. This packet represents the pre-clinical health requirements for your clinical program. **You should complete these requirements as soon as possible** due to the amount of time involved in scheduling appointments, obtaining titers, and completing other requirements. The costs of meeting these requirements are your responsibility and may not be covered by your health insurance. If you have questions about individual program requirements, please reach out to your program's Clinical Compliance Coordinator.

You may have your physical, titers, and immunizations/screenings performed at UConn Student Health and Wellness at the Hilda Williams Building or by your primary healthcare provider. You may also receive any required immunizations, PPD tests, Tdap, and flu shots at most pharmacies or travel clinics.

You will not be permitted to participate in clinical training experiences if your health records are incomplete.

Important Notes on Required Documentation

1. To be approved, all documents must be clearly legible and include:
   - ✓ Student name
   - ✓ Healthcare provider name
   - ✓ Date performed
   - ✓ For lab results, reports should include both ***qualitative*** AND ***quantitative*** results
2. Equivocal or negative titers will require repeat immunization dosing and repeat titers per the CDC Advisory Committee on Immunization Practices (ACIP) guidelines and UConn protocols.

Checklist of Clinical Health Requirements to be completed:

PART 1 – Immunization History *(page 2-3)*

☐ Hepatitis B – Minimum: 3-dose vaccine series & positive Hepatitis B quantitative surface antibody (HBsAb) titer

☐ Varicella – Minimum: 2 doses of vaccine (or documentation of disease) & positive Varicella quantitative IgG titer

☐ MMR – Minimum: 2 doses of vaccine & positive quantitative IgG titers for measles, mumps, and rubella

☐ Current Tetanus vaccine (Please check individual program requirements for Td vs Tdap)

PART 2 – Physical Examination *(page 4)*

☐ Physical Examination Form – Note: Color Vision Testing ☐ IS ☐ IS NOT required for your program

PART 3 – Annual Tuberculosis Screening *(page 5)*

☐ Skin Test [PPD (2-visit) or 2-Step PPD (4-visit)] **or** ☐ Blood Test (QuantiFERON Gold/T-Spot Blood) **or** ☐ Chest X-Ray/Annual Symptom Screening Questionnaire

Submitting Your Documents

Submit all documents listed below to Complio at **http://adb.uconn.edu** **(log in with your UConn NetID and password)**. To be compliant, you must upload documents AND associate them with the appropriate compliance categories in Complio so they can be reviewed and approved. ***Submit requirements and steps as they are completed—do not wait until you have completed all requirements to submit your documentation!*** Submissions generally take 2-3 business days for approval, so please plan accordingly for program deadlines.

- ☐ Physical Exam Form (page 4) uploaded
- ☐ Hepatitis B Form (page 2) and Titer Lab Work if applicable
- ☐ Varicella Form (page 2) and Titer Lab Work if applicable
- ☐ MMR Form (page 3) and Titer Lab Work if applicable
- ☐ Tetanus Vaccine Form (page 3) uploaded
- ☐ Tuberculosis Form (page 5) uploaded

Note for Incoming Students: You must submit all UConn-required health documents separately to Student Health & Wellness via **https://myhealth.uconn.edu**. These requirements are separate from clinical requirements, which must be submitted via Complio.

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PART 1: Immunization History – To be completed and signed by healthcare provider if used as the primary submission of immunization history information.

Note: All items are required.

Hepatitis B – A minimum of three doses of vaccine and positive quantitative surface antibody (HBsAb) titer is required. If titer is negative, repeat doses are required, followed by repeat titer. ***Note: Lab work is required in addition to immunization history, and must show both quantitative and qualitative (positive/negative) results.***

Hepatitis B Primary Immunization Series					
Dose #1 Date:	____/____/___	Dose #2 Date:	____/____/___	Dose #3 Date:	____/____/___

Hepatitis B Primary (HBsAb) Titer				
Titer Date:	____/____/____	Result:	☐ Positive ☐ Negative/Equivocal	☐ Titer Lab work Attached

Hepatitis B Repeat Immunization *(required only if primary titer is negative)*					
Repeat Dose #1 Date:	____/____/___	Repeat Dose #2 Date:	____/____/___	Repeat Dose #3 Date:	____/____/___

Hepatitis B Repeat HBsAb Titer *(required only if primary titer is negative)*				
Repeat Titer Date:	____/____/____	Result:	☐ Positive ☐ Negative/Equivocal	☐ Titer Lab work Attached

Varicella – A minimum of two doses of vaccine or documented history of disease and positive quantitative IgG titer is required. If primary titer is negative, booster (or repeat two-dose series) required followed by repeat titer. ***Note: Lab work is required in addition to immunization history, and must show both quantitative and qualitative (positive/negative) results.***

Varicella Primary Immunization Series			
Dose #1 Date:	____/____/___	Dose #2 Date:	____/____/___

Varicella Primary IgG Titer				
Titer Date:	____/____/____	Result:	☐ Positive ☐ Negative/Equivocal	☐ Titer Lab work Attached

Varicella Repeat Immunization *(required only if primary titer is negative)*			
Repeat Dose #1 Date:	____/____/___	Repeat Dose #2 Date:	____/____/___

Varicella Repeat IgG Titer *(required only if primary titer is negative)*				
Repeat Titer Date:	____/____/____	Result:	☐ Positive ☐ Negative/Equivocal	☐ Titer Lab work Attached

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PART 1: Immunization History continued

Measles, Mumps & Rubella (MMR) – A minimum of two doses of vaccine and positive quantitative IgG titer for all three diseases. If one or more titers are negative, booster (or repeat two-dose series) required followed by repeat titer(s). ***Note: Lab work is required in addition to immunization history, and must show both quantitative and qualitative (positive/negative) results.***

MMR Primary Immunization Series			
Dose #1 Date:	____/____/___	Dose #2 Date:	____/____/___

MMR Primary IgG Titers					
Measles	Titer Date:	____/____/____	Result:	☐ Positive ☐ Negative/Equivocal	☐ Titer Lab work attached
Mumps	Titer Date:	____/____/____	Result:	☐ Positive ☐ Negative/Equivocal	☐ Titer Lab work attached
Rubella	Titer Date:	____/____/____	Result:	☐ Positive ☐ Negative/Equivocal	☐ Titer Lab work attached

MMR Repeat Immunization *(required only if primary titer is negative)*			
Repeat Dose #1 Date:	____/____/____	Repeat Dose #2 Date:	____/____/____

MMR Repeat IgG Titers *(required only if primary titer is negative)*					
Measles	Titer Date:	____/____/____	Result:	☐ Positive ☐ Negative/Equivocal	☐ Titer Lab work attached
Mumps	Titer Date:	____/____/____	Result:	☐ Positive ☐ Negative/Equivocal	☐ Titer Lab work attached
Rubella	Titer Date:	____/____/____	Result:	☐ Positive ☐ Negative/Equivocal	☐ Titer Lab work attached

Tetanus – Current Tdap (Tetanus, Diphtheria, and Acellular Pertussis) or Td (Tetanus & Diphtheria) immunization administered within the last 10 years. When only Td is required, show proof of initial Tdap. (Please check individual program requirements for Td vs Tdap.)

Current Tetanus Booster		
☐ Tdap ☐ Td	Date:	____/____/____

Healthcare Provider Attestation

The information presented on this form is true and accurate to the best of my knowledge.

Provider Signature: _____ **Date:** ____/____/____ **Phone:** _____

Provider Name (printed): _____ **Address:** _____

Provider Type: ☐ MD ☐ DO ☐ APRN ☐ PA

Name _____ DOB_____ PeopleSoft # _____ Program _____

PART 2: Physical Examination – To be completed by healthcare provider

Note: All items are required except where indicated as optional.

VITAL SIGNS

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

CHECK NORMAL/ABNORMAL FOR EACH AREA

	Normal	Abnormal	Description of Abnormal Findings
Appearance			
Nutrition			
Skin			
Head/Neck			
Glands			
Eyes			
Ears			
Nose			
Mouth/Teeth/Throat			
Chest			
Lungs			
Heart			
Abdomen			
Back			
Musculo-Skeletal			
Testes (Optional)			
Genitalia/Pelvic (Optional)			
Neurological			
Emotional/Psychological			

COLOR VISION screening is required unless otherwise indicated on your instruction page.

Color Vision (6-plate minimum)	
☐ Normal	☐ Deficient

Healthcare Provider Attestation of Student Fitness for Participation in Clinical Experiences

I have reviewed this student's health history and conducted a physical examination. The information presented on this form is true and accurate to the best of my knowledge. It is my opinion that this student is in satisfactory physical condition to participate fully in clinical experiences required by the program of study. I have noted any limitations below.

Limitations: _____

_____

The information presented on this form is true and accurate to the best of my knowledge.

Provider Signature: _____ **Date:** ____/____/____ **Phone:** _____

Provider Name (printed): _____ **Address:** _____

Provider Type: ☐ MD ☐ DO ☐ APRN ☐ PA

Name _____ DOB_____ PeopleSoft # _____ Program _____

PART 3: Annual Tuberculosis Requirements – To be completed by healthcare provider

On an annual basis, you are required to provide proof that you are free of tuberculosis through one of the following:

1) TB skin test: either a) a regular (2-visit) Mantoux PPD or b) a two-step (4-visit) Mantoux PPD performed 7-21 days apart per CDC protocols (Please check individual program requirements for the type of PPD test accepted)
2) Blood Test: (recommended for BCG-vaccinated individuals.)
3) Chest X-Ray: An annual symptom screening questionnaire if a chest x-ray has been previously required.

If you are unsure which screening method is appropriate for your program, please contact your program's Clinical Compliance Coordinator.

Option 1A: Mantoux PPD

Date Administered: ____/____/____ Signature: _____
Date Read: ____/____/____
Result in mm induration: _____ Signature: _____
PPD Result: ☐ Negative ☐ Positive

Option 1B: Two-Step Mantoux PPD (Required for Nursing, AHS, SLHS)

PPD Step #1

Date Administered: ____/____/____ Signature: _____
Date Read: ____/____/____
Result in mm induration:_____ Signature: _____
Step #1 PPD Result: ☐ Negative ☐ Positive

PPD Step #2

Date Administered: ____/____/____ Signature: _____
Date Read: ____/____/____
Result in mm induration:_____ Signature: _____
Step #2 PPD Result: ☐ Negative ☐ Positive

Option 2: Blood Test

Date: ____/____/____ ☐ QuantiFERON Gold ☐ T-Spot ☐ Lab Work Attached
Result: ☐ Positive *(requires chest X-Ray)* ☐ Negative
Signature:_____

Option 3: Chest X-Ray *(Required if past or current positive PPD or positive blood test.)*

Date of X-Ray: ____/____/____ X-Ray Results: ☐ Normal ☐ Abnormal
☐ Radiology Report Attached ☐ Annual TB Screening Questionnaire Attached

Healthcare Provider Attestation

The information presented on this form is true and accurate to the best of my knowledge.

Provider Signature: _____ **Date:** ____/____/____ **Phone:** _____
Provider Name (printed): _____ **Address:** _____
Provider Type: ☐ MD ☐ DO ☐ APRN ☐ PA