UNIVERSITY OF CONNECTICUT STUDENT HEALTH HISTORY FORM

Submit all completed forms and any attachments by scanning and uploading to the Student Health Portal - myHealth.uconn.edu

THIS FORM MUST BE SUBMITTED BY JULY 1 FOR FALL SEMESTER AND JANUARY 1 FOR SPRING SEMESTER

Student Last Name:	Student First Name:	Student Middle Name:	Pronouns:

Date of Birth: MM/DD/YYYY	Sex Assigned at Birth:	Gender Identity:	Net ID:	Preferred Name:

IMMUNIZATION HISTORY

1. MEASLES, MUMPS, RUBELLA (MMR) Vaccination - required of all students born after 1957

OPTION 1: Measles, Mumps, Rubella (MMR) Vaccination (First dose must be given on or after your first birthday to be accepted)

Dose #1	Dose #2
MM / DD / YYYY	MM / DD / YYYY

OPTION 2: In lieu of proof of vaccination above, a titer showing immunity to each individual disease is an acceptable alternative to the vaccination.

Measles Titer Result: ☐ Immune ☐ Not immune Date ______________ MM/DD/YYYY
Mumps Titer Result: ☐ Immune ☐ Not immune Date ______________ MM/DD/YYYY
Rubella Titer Result: ☐ Immune ☐ Not immune Date ______________ MM/DD/YYYY

*If not immune, you are required to receive a booster MMR and repeat the titer or receive two MMR vaccines in lieu of the booster and titer

OPTION 3: An incidence of disease will take the place of a vaccine requirement. (Must be filled in by a physician/APRN/PA)

Measles Disease	Mumps Disease	Rubella Disease
MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY

2. VARICELLA Vaccination - required for all students born after 1979

OPTION 1: Varicella Vaccination (First dose must be given on or after your first birthday to be accepted)

Dose #1	Dose #2
MM / DD / YYYY	MM / DD / YYYY

OPTION 2: In lieu of proof of vaccination above, a titer showing immunity to the disease is an acceptable alternative to the vaccination.

Varicella Titer Result: ☐ Immune ☐ Not immune Date ______________ MM/DD/YYYY

*If not immune, you are required to receive a booster and repeat the titer or receive two Varicella vaccines in lieu of the booster and titer

OPTION 3: An incidence of disease will take the place of a vaccine requirement. (Must be filled in by a physician/APRN/PA)

Varicella Disease MM/DD/YYYY

3. MENINGOCOCCAL(MCV4) Vaccination - Required of all students living in University housing Supporting documentation required

☐Menactra ☐ Menveo ☐Nimenrix ☐ MenQuanfi

Must cover strains A, C, Y, W-135
Polysaccharide strain not accepted

Date MM / DD / YYYY

Vaccination must have been given within 5 years of your first day of classes at UConn.

Exceptions to requirement:

☐ I will not be living in campus owned housing.
☐ I am over 29 years of age.

4. CLEARANCE TO PLAY CLUB SPORTS

All Club Sports athletes must submit Clearance to Play verification from their healthcare provider that states they have had a physical examination within one year of the sport season's start date.

Date of last physical exam (MM/DD/YYYY): _____ / _____ / ________

X__________
Provider initial

By initialing, I certify that the student named above is healthy and cleared to participate in any Club Sports related activity for the coming academic year.

5. SICKLE CELL TRAIT TEST - Required of all NCAA Student Athletes ONLY

The University of Connecticut mandates that all NCAA Division I student-athletes provide proof of their Sickle Cell Trait Testing status prior to participating in any athletic activities at UConn. A copy of the lab report must be uploaded to your Student Health Portal.

6. Tuberculosis(TB) Risk Questionnaire required of all students: located on Student Health Portal at myhealth.uconn.edu

Signature of Health Care Practitioner (MD / DO / APRN / PA)

By signing below, I am certifying the accuracy of the information documented on the Student Health History Form.

Signature____Date___________ Phone________________

Name (print) : Address:

NPI#:

UNIVERSITY OF CONNECTICUT

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Student Last Name	Student First Name	Net ID

Consent for Treatment/ Insurance Release Form

I hereby authorize UConn Student Health and Wellness staff to provide medical and mental health treatment, which may include medications for treatment of illnesses/injuries, and to arrange for emergency medical care if circumstances render me incapable of making such decision.

I understand that to facilitate the best care for my wellbeing, it may be necessary to share my medical information between departments within Student Health and Wellness. This information will be shared with the intended purpose of coordinating my care in the event that I require an urgent or emergent on-call response.

I hereby authorize Student Health and Wellness to disclose my 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 and Wellness staff.

I understand that Student Health and Wellness staff may disclose my medical records and/or information from such records to appropriate University personnel for purposes of treatment, payment and healthcare operations, and hereby consent to such disclosures.

I may opt to schedule a telehealth appointment. Telehealth allows my medical provider and/or mental health provider to diagnose, consult, treat and educate using video-conferencing or telephonic services. By agreeing to a scheduled telehealth I hereby consent to participating in treatment and/or psychotherapy via video-conferencing or telephonic services. I understand that the same confidentiality standards that apply to a medical or mental health in-person visit also apply to a Telehealth visit.

I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our therapy sessions could be disrupted or distorted by technical failures. My provider may, at any time, determine that due to certain circumstances, Telehealth is no longer appropriate, and recommend that resumption of in-person sessions.

I also understand there are exceptions to confidentiality wherein Student Health and Wellness may be required to disclose information from my medical record, including mandatory reporting of child, elder, and dependent adult abuse and in the case of credible threats of violence toward a reasonably identifiable person.

By signing below, I authorize Student Health and Wellness to submit to my insurance and agree to take responsibility for all charges whether or not paid by insurance. I acknowledge that my PeopleSoft account may be put “on hold” for unpaid charges incurred at Student Health and Wellness.

Signature(s) below indicates understanding of an agreement with the above information.

Student Signature:	Date:	Parent/Guardian Signature:	Date:
X		X **If you are under the age of 18 years old, your parent/guardian must sign.**	