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 at least ***quantitative*** results (qualitative is optional)
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 & positive measles, mumps and rubella titers

☐ Current TDAP or 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 (TB) Screening *(page 5)* ***CHOOSE 1***

If you have NO prior History of TB and NO history of a positive TB screening test:

- ☐ PREFERRED Blood Test (QuantiFERON Gold/T-Spot Blood) OR
- ☐ 2-Step Mantoux PPD Skin Test (4-visits, 1-3 weeks apart) OR
- ☐ Baseline Single PPD Test [PPD (2-visits)

If you DO have a history of TB or history of a positive screening test:

- ☐ Annual TB Symptom Screening Questionnaire (*page 6*)
- ☐ Chest X-Ray results (*most recent*)
- ☐ Additional documentation of treatment completion signed by a healthcare provider

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.

Name_____DOB_____PeopleSoft # _____ Program_____

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 to show at least quantitative and if possible qualitative (positive/negative) results.***

Hepatitis B Primary (Pediatric) 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 to show at least quantitative and if possible qualitative (positive/negative) results.***

Varicella Primary (Pediatric) 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 to show at least quantitative and if possible qualitative (positive/ negative) results.**

MMR Primary (Pediatric) 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

You are required to meet the clinical program requirements by providing documentation that you are free of tuberculosis (TB) through one of the following ways:

If you answer NO to a history of TB and NO to a history of positive TB screening tests:

A) PREFERRED METHOD TB Blood Test: QuantiFERON Gold or T-Spot
B) 2-step Mantoux PPD (4-visits, performed 7-21 days apart)
C) Single Baseline PPD test (2-visits)

If you answer YES to a history of TB and/or YES to a history of positive TB screening tests:

D) Annual Symptom Screening Questionnaire is required (see page 6)
Chest X-Ray results (most recent)
Additional signed documentation of treatment completion

Option A: Blood Test (Preferred Method)

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

Option B: Two-Step Mantoux PPD

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 C: Single Baseline Mantoux PPD

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

Option D: Annual TB Screening Questionnaire *(Required if past or current positive PPD or blood test.)*

☐ Annual TB Screening Questionnaire (Page 6) ☐ Radiology Report Attached
Date of Last X-Ray: ____/____/____ X-Ray Results: ☐ Normal ☐ Abnormal Treatment Completed: **Y N**

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

PART 3: Annual Tuberculosis (TB) Screening Questionnaire

Please answer the following questions:

Have you experienced any of the following symptoms within the past year?

	YES	NO
• Persistent productive cough?	☐	☐
• Coughing up blood?	☐	☐
• Chest pain?	☐	☐
• Shortness of breath / difficulty breathing?	☐	☐
• Unexplained fever lasting more than 3 days?	☐	☐
• Unexplained night sweats?	☐	☐
• Unexplained sudden weight loss?	☐	☐
• Unexplained fatigue / run down feeling?	☐	☐
• Unexplained swollen lymph nodes or masses in your armpit or neck area?	☐	☐