2017 Clinical Rotation Health Review Form

Part 1: To be completed by Student

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>MI</th>
<th>Date of Birth</th>
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PeopleSoft ID # | Email | Cell or Local Phone |
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Program

- ☐ Allied Health Sciences
- ☐ Nursing
- ☐ Pharmacy
- ☐ Physical Therapy
- ☐ Psychology
- ☐ Social Work
- ☐ Speech & Hearing

CAMPUS

- ☐ Avery Point
- ☐ Hartford
- ☐ Stamford
- ☐ Storrs
- ☐ Waterbury

Permanent Home Information:

<table>
<thead>
<tr>
<th>Home Phone</th>
<th>Name / Relationship</th>
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<table>
<thead>
<tr>
<th>Street Address</th>
<th>Home Phone Cell/Work Phone</th>
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<tr>
<th>City State Zip</th>
<th>Street Address</th>
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Any questions concerning your requirements and submission deadlines should be directed to your Program Contact listed here:

**Allied Health Sciences (including Dietetics, Medical Technology & Diagnostic Genetic Sciences)**

- **Bambi Mroz**
  - Business Services Supervisor
  - 358 Mansfield Rd, Unit 1101
  - Storrs, CT 06269-1101
  - Phone: 860-486-0013
  - Fax: 860-486-5375
  - bambi.mroz@uconn.edu

**Nursing**

- **Amelia Hinchliffe**
  - Office of Admission & Enrollment Services
  - 231 Glenbrook Road, Unit 4026
  - Storrs, CT 06269-4026
  - Phone: 860-486-4104
  - Fax: 860-486-7975
  - amelia.hinchliffe@uconn.edu

**Pharmacy**

- **Mary Ann Phaneuf**
  - Assistant Director, Experiential Education
  - 69 North Eagleville Road Unit 3092
  - Storrs, CT 06268
  - Phone: 860-486-2999
  - Fax: 860-486-9095
  - maryann.phaneuf@uconn.edu

**Physical Therapy**

- **Rachel C. Chassé-Terebo**
  - Immunization & Clinical Compliance Coordinator
  - 3107 Horsebarn Hill Road, Unit 1101
  - Storrs, CT 06269-1101
  - Phone: 860-486-1854
  - Fax: 860-486-1588
  - rachel.chasse@uconn.edu

**Psychology**

- **Debbie Vardon**
  - Administrative Manager, Clinical Training Program
  - 406 Babidge Road Unit 1020
  - Storrs, CT 06269-1020
  - Phone: 860-486-2057
  - Fax: 860-486-2760
  - debra.vardon@uconn.edu

**Social Work**

- **Cheryl Jackson-Morris, MSW**
  - Associate Director for Field Education
  - 38 Prospect Street
  - Hartford, CT 06103
  - Phone: 860-570-9161, ext. 3
  - Fax: 860-570-9311
  - cheryl.jackson-morris@uconn.edu

**Speech, Language, and Hearing Sciences**

- **Sirrah Galligan**
  - Academic Program Coordinator
  - 850 Bolton Road, Unit 1085
  - Storrs, CT 06269
  - Phone: 860-486-2817
  - Fax: 860-486-4948
  - slhs@uconn.edu
Clinical Rotation Health Review Form

Part 2: Immunizations and Lab work to be completed by Healthcare Provider

- Dates of both immunizations and titers must be provided for acceptance to clinical rotation.
- Titors are ☐ PREFERRED ☐ REQUIRED over immunizations (check one)
- Evidence of disease is not an acceptable method of immunity
- Only students registered at the Storrs Campus are eligible for services at Student Health Services

In addition to the basic requirements listed on the UConn Student Health Services Mandatory Health History Form, the following lab work is needed depending on the student’s program and clinical site.

→ Titors for ☐ Measles, ☐ Mumps, ☐ Rubella, ☐ Varicella, ☐ Hepatitis B, ☐ Polio

*NOTE: Negative immunity response to the disease states listed above may require boosters, immunization and/or blood tests. YOU are responsible for scheduling follow-ups to complete the series.

<table>
<thead>
<tr>
<th>DISEASE</th>
<th>TITER DATE</th>
<th>TITER RESULTS (Immune = Positive)</th>
<th>VACCINATION 1  DATE</th>
<th>VACCINATION 2  DATE</th>
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<tbody>
<tr>
<td>MEASLES</td>
<td>/ /</td>
<td>☐ IMMUNE ☐ NON-IMMUNE*</td>
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<tr>
<td>MUMPS</td>
<td>/ /</td>
<td>☐ IMMUNE ☐ NON-IMMUNE*</td>
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<tr>
<td>RUBELLA</td>
<td>/ /</td>
<td>☐ IMMUNE ☐ NON-IMMUNE*</td>
<td>/ /</td>
<td>/ /</td>
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<tr>
<td>VARICELLA</td>
<td>/ /</td>
<td>☐ IMMUNE ☐ NON-IMMUNE*</td>
<td>/ /</td>
<td>/ /</td>
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<tr>
<td>POLIO</td>
<td>/ /</td>
<td>☐ IMMUNE ☐ NON-IMMUNE*</td>
<td>1ST O/IPV DATE</td>
<td>2ND O/IPV DATE</td>
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<tr>
<td>HEPATITIS B**</td>
<td>/ /</td>
<td>☐ IMMUNE ☐ NON-IMMUNE*</td>
<td>1ST HEP B DATE</td>
<td>2ND HEP B DATE</td>
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**A Hepatitis B Titer is required only if the Hepatitis B series has been completed within the past 2 years, unless checked above.

Provider must sign to attest to immunization information

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

CLINICIAN SIGNATURE: ___________________________ DATE: __/___/____ PHONE: (______) _____-______-

CLINICIAN NAME (PLEASE PRINT) ___________________________ ADDRESS: ___________________________

CONTINUE TO PART 3 FOR THE MANDATORY PHYSICAL EXAM
Clinical Rotation Health Review Form

Part 3: Physical Examination to be completed by Healthcare Provider

<table>
<thead>
<tr>
<th>Last Name</th>
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<th>MI</th>
<th>PeopleSoft ID #</th>
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### Vital Signs

<table>
<thead>
<tr>
<th>BP:</th>
<th>Pulse:</th>
<th>Height:</th>
<th>Weight:</th>
<th>Date of Birth</th>
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**VNL**

*Check Box for within normal limits*

- Head/ears/nose/throat
- Mouth/teeth
- Eyes/ophthalmoscopic/color vision deficiency screening
- Spine/neck
- Nodes
- Chest/lungs
- Heart
- Abdomen
- Breast/Testicles
- Extremities
- Skin
- Neurologic
- Psychological

**Impression**

**Additional information**

I have examined this person and find no medical condition that would prohibit him/her/from fully participating in their Clinical Rotation. **SIGNATURE OF HEALTH CARE PRACTITIONER** *(MD / DO / APRN / PA) (Please circle one)*

**CLINICIAN SIGNATURE:** ___________________________________________  **DATE:** _____/_______/_________  **PHONE:** _(_______) _______-__________

**CLINICIAN NAME (PLEASE PRINT)** _____________________________________  **ADDRESS:** ______________________________________________________