

Part 1: To be completed by Student

LAST NAME		FIRST NAME		MI	Date of Birth
PeopleSoft ID #		Email		Cell or Local Phone	
Program <input type="checkbox"/> Allied Health Sciences <input type="checkbox"/> Nursing <input type="checkbox"/> Pharmacy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Psychology <input type="checkbox"/> Social Work <input type="checkbox"/> Speech & Hearing					CAMPUS <input type="checkbox"/> Avery Point <input type="checkbox"/> Hartford <input type="checkbox"/> Stamford <input type="checkbox"/> Storrs <input type="checkbox"/> Waterbury
Permanent Home Information:			Notify in Case of Emergency:		
Home Phone			Name / Relationship		
Street Address			Home Phone Cell/Work Phone		
City State Zip			Street Address		
			City State Zip		

<p>Any questions concerning your requirements and submission deadlines should be directed to your Program Contact listed here:</p>	<p>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</p>
<p>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</p>	<p>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</p>
<p>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</p>	<p>Psychology Debbie Vardon Administrative Manager, Clinical Training Program 406 Babbidge Road Unit 1020 Storrs, CT 06269-1020 Phone: 860-486-2057 Fax: 860-486-2760 debra.vardon@uconn.edu</p>
<p>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</p>	<p>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</p>

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.
- Titers 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.

→ Titers for Measles, Mumps, Rubella, Varicella, Hepatitis B, Polio

A copy of the lab results must accompany this form.

Last Name	First Name	MI	PeopleSoft ID #
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DISEASE	TITER DATE	TITER RESULTS (Immune = Positive)	VACCINATION 1 DATE	VACCINATION 2 DATE
MEASLES	/ /	<input type="checkbox"/> IMMUNE <input type="checkbox"/> NON-IMMUNE*	/ /	/ /
MUMPS	/ /	<input type="checkbox"/> IMMUNE <input type="checkbox"/> NON-IMMUNE*	/ /	/ /
RUBELLA	/ /	<input type="checkbox"/> IMMUNE <input type="checkbox"/> NON-IMMUNE*	/ /	/ /
VARICELLA	/ /	<input type="checkbox"/> IMMUNE <input type="checkbox"/> NON-IMMUNE*	/ /	/ /
POLIO	/ /	<input type="checkbox"/> IMMUNE <input type="checkbox"/> NON-IMMUNE*	1 ST O/IPV DATE / /	2 ND O/IPV DATE / /
			3 RD O/IPV DATE / /	BOOSTER DATE / /
HEPATITIS B**	/ /	<input type="checkbox"/> IMMUNE <input type="checkbox"/> NON-IMMUNE*	1 ST HEP B DATE / /	2 ND HEP B DATE / /
			3 RD HEP B DATE / /	

**A Hepatitis B Titer is required only if the Hepatitis B series has been completed within the past 2 years, unless checked above.

***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.**

<p>TETANUS BOOSTER (Must have been given within the past 10 years) <i>Tetanus, diphtheria & pertussis is the current preferred vaccination for all entering clinical sites</i></p> <p><input type="checkbox"/> Tdap <input type="checkbox"/> Td DATE: / /</p>	<p>INFLUENZA VACCINATION (between October & March of every calendar year):</p> <p>DATE: / / Brand Name:</p> <p>Lot # Exp. Date: / /</p>
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<p>TUBERCULOSIS: Either IGRA/BAMT blood test or tuberculosis skin test (TST)/ PPD (below)</p>	<p>IGRA/BAMT Blood test, either <input type="checkbox"/> Quantiferon <input type="checkbox"/> T-Spot</p>	<p>IGRA/BAMT Date: / /</p>	<p>Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate</p>
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TST/ PPD	DATE PLANTED: / /	DATE READ: mm ____	RESULTS <input type="checkbox"/> Negative <input type="checkbox"/> Positive	2nd TST/PPD (if a 2- Step PPD is required)	DATE PLANTED: / /	DATE READ: mm ____	RESULTS <input type="checkbox"/> Negative <input type="checkbox"/> Positive
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<p><i>If Positive, Chest x-ray is needed</i></p> <p>X-RAY DATE: / /</p> <p>RESULTS:</p>	<p>HX of TB Treatment and Completion Date (Specify type)</p>	<p>Use this section to note immunization concerns (i.e. non converter, BCG vaccinated):</p>
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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: _____

Part 3: Physical Examination to be completed by Healthcare Provider

Last Name		First Name		MI	PeopleSoft ID #
Vital Signs					Date of Birth
BP:		Pulse:	Height:	Weight:	
WNL	<i>Check Box for within normal limits</i>				
	Head/ears/nose/throat				
	Mouth/teeth				
	Eyes/opthalmoscopic/color vision deficiency screening				
	Spine/neck				
	Nodes				
	Chest/lungs				
	Heart				
	Abdomen				
	Breast/Testicles				
	Extremities				
	Skin				
	Neurologic				
	Psychological				
Impression					
Additional information					
<p>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) <i>(Please circle one)</i></p>					
CLINICIAN SIGNATURE: _____		DATE: ____/____/____		PHONE: (____) ____-____	
CLINICIAN NAME (PLEASE PRINT) _____		ADDRESS: _____			