TUBERCULOSIS (TB) RISK QUESTIONNAIRE

3. REQUIRED OF ALL STUDENTS LIVING IN UNIVERSITY HOUSING

If you answered NO to all questions, no further action is required. If you answered YES to any question in 4b through 4d you must have a TB blood or skin test. A chest x-ray is unacceptable for 4b – 4d YES answers.

No exemption for prior BCG. If you have received BCG in the past, a TB blood test is recommended however, a TB skin test is accepted.

TB BLOOD TEST (IGRA) Recommended if prior BCG
☐ Quantiferon ☐ T-Spot
Date: __________________________ Result: __________________________
☐ NEG ☐ POS

TB SKIN TEST (PPD)
Date Planted: __________________________
Date Read: __________________________
Interpretation: __________________________
☐ NEG ☐ POS
mm of induration: __________________________

CHEST X-RAY
• Only accepted/required if past or current positive TB skin or blood test.
• Not required if completed treatment for TB

Chest X-ray Date: __________________________
☐ Normal ☐ Abnormal

Submit all completed forms and any attachments by scanning and uploading to the Student Health Portal myHealth.uconn.edu
5. STRONGLY RECOMMENDED VACCINATIONS

TETANUS, DIPHTHERIA, PERTUSSIS
☐ Tdap ☐ Td
(inside the last 10 years)

MENINGOCOCCAL SEROGROUP B
☐ Trumenba (MenB-FHbp)
☐ Bexsero (MenB-4C)

HEPATITIS B VACCINATION SERIES
Dose #1: ☐ MM/DD/YYYY ☐ Dose #2: ☐ MM/DD/YYYY
Dose #3: ☐ MM/DD/YYYY

HUMAN PAPILLOMAVIRUS
☐ HPV4 ☐ HPV9

6. REQUIRED OF ALL NCAA STUDENT-ATHLETES

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 accompany this form.

7. 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.

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.

Date of Last Physical Exam (MM/DD/YYYY): _____ / _____ / ________

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

By signing below, I am certifying the accuracy of the information documented on pages 1 & 2 of Health History Form A.

Signature: ___________________________ Date: ___________ Phone: _______________________

Name (print): ___________________________ Address: ___________________________ NPI#: ___________________________

List of High Risk Tuberculosis Countries for TB Questionnaire on page 1 of Student Health History Form A

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