UCONN Student Health Services 2015 2016 Mandatory Health History Form Page 1

www.shs.uconn.edu UCONN SHS, U-4011 234 Glenbrook Rd, Storrs, CT 06269 FAX: 860-486-5300 PHONE: 860-486-4700

DEADLINE This form must be submitted by July 1st for Fall semester OR January 1st for Spring Semester
A $50 non-refundable fee will be applied to your fee bill if you are not compliant with your immunizations by the 10th day of classes.

Last Name	First Name	MI

Date of Birth: MM/DD/YYYY	Gender ☐ Male ☐ Female ☐ Other	Net ID

YEAR BEGINNING _____ ☐ Fall ☐ Spring *(Students attending UCONN School of Law and UCHC should contact those schools directly for their form.)* *(Online students must notify SHS of this student status).*
CAMPUS ATTENDING: ☐ STORRS ☐ AVERY POINT ☐ HARTFORD ☐ STAMFORD ☐ TORRINGTON ☐ WATERBURY

TO BE IN COMPLIANCE & BE ABLE TO REGISTER, ALL STUDENTS MUST COMPLETE SECTIONS 1 & 2

A physical exam is NOT required. Questions? Visit our Frequently Asked Questions (FAQ's): www.shs.uconn.edu Immunization FAQ

1	Measles, Mumps, Rubella (MMR) Combined Vaccination	Dose #1 _____ MM / DD / YYYY	Dose #2 _____ MM / DD / YYYY	**For all vaccinations in Sections 1 & 2** Must have either 2 doses, OR a titer showing immunity OR the disease. First Dose must be after 12 months of age & 28 days apart.		
	Measles Single Vaccination	Dose #1 _____ MM / DD / YYYY	Dose #2 _____ MM / DD / YYYY	Titer _____ MM / DD / YYYY	Result [ ] Immune [ ] Not immune	Measles Disease _____ MM / DD / YYYY
	Mumps Single Vaccination	Dose #1 _____ MM/ DD / YYYY	Dose #2 _____ MM / DD / YYYY	Titer _____ MM / DD / YYYY	Result [ ] Immune [ ] Not immune	Mumps Disease _____ MM / DD / YYYY
	Rubella Single Vaccination	Dose #1 _____ MM / DD / YYYY	Dose #2 _____ MM / DD/ YYYY	Titer _____ MM / DD / YYYY	Result [ ] Immune [ ] Not immune	Rubella Disease _____ MM / DD / YYYY
2	Varicella Vaccination Only for those born after 1/1/80	Dose #1 _____ MM / DD / YYYY	Dose #2 _____ MM / DD / YYYY	Titer _____ MM / DD / YYYY	Result [ ] Immune [ ] Not immune	Chicken Pox Disease _____ MM / DD / YYYY

SECTIONS 3 & 4 ARE FOR STORRS CAMPUS STUDENTS

While sections 3 & 4 are required only for Storrs Campus students, completion of these sections will insure a smoother transition when transferring.

3	Meningitis Vaccination Must cover strains A, C, Y, W-135 (Menactra, Menveo, Mencevax,, Nimenrix)	_____ MM / DD / YYYY	Vaccination must have been given within 5 years of your 1st day of classes at UConn.	Exemptions to Meningitis: [ ] I will not be living in campus owned housing. [ ] I am over 29 years of age.

4 Tuberculosis (TB) Risk Questionnaire – a. through d. To be answered by the Student. This is Mandatory for All Students at the Storrs Campus. 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.
IF you answer NO to all questions no further action is required.
IF you answer YES to any question b-d you must have a TB blood or skin test. A chest x-ray is not accepted for b – d YES answers.

a. Have you ever had a positive tuberculosis skin or blood test in the past? See 4C. Chest X-ray section below for Yes answer	☐ Yes ☐ No
b. To the best of your knowledge have you ever had close contact with anyone who was sick with tuberculosis (TB)?	☐ Yes ☐ No
c. Were you born in one of the countries listed below? *If yes circle country*	☐ Yes ☐ No
d. Have you traveled to or lived for more than one month in one or more of the countries listed below? *If yes circle country*.	☐ Yes ☐ No

Afghanistan, Algeria, Angola, Anguilla, Argentina, Armenia, Azerbaijan, Bangladesh, Belarus, Belize, Benin, Bhutan, Bolivia, Bosnia & Herzegovina, Botswana, Brazil, Brunei Darussalam, Bulgaria, Burkina Faso, Burundi, Cambodia, Cameroon, Cabo Verde, Central African Republic, Chad, China, China-Macao, China-Hong Kong, Colombia, Comoros, Congo, Congo DR, Cote d'Ivoire, Djibouti, Dominican Rep., Ecuador, El Salvador, Equatorial Guinea, Eritrea, Estonia, Ethiopia, Fiji, French Polynesia, Gabon, Gambia, Georgia, Ghana, Greenland, Guam, Guatemala, Guinea, Guinea-Bissau, Guyana, Haiti, Honduras, India, Indonesia, Iran, Iraq, Kazakhstan, Kenya, Kiribati, Korea-DPR, Korea-Rep, Kyrgyzstan, Kuwait, Lao PDR, Latvia, Lesotho, Liberia, Libya, Lithuania, Madagascar, Malawi, Malaysia, Maldives, Mali, Marshall Islands, Mauritania, Mauritius, Mexico, Micronesia, Moldova-Rep, Mongolia, Montenegro, Morocco, Mozambique, Myanmar, Namibia, Nauru, Nepal, New Caledonia, Nicaragua, Niger, Nigeria, Northern Mariana Islands, Pakistan, Papua New Guinea, Paraguay, Palau, Panama, Peru, Philippines, Poland, Portugal, Qatar, Romania, Russian Federation, Rwanda, Sao Tome & Principe, Senegal, Seychelles, Sierra Leone, Singapore, Solomon Islands, Somalia, South Africa, South Sudan, Sri Lanka, St. Vincent & The Grenadines, Sudan, Suriname, Swaziland, Taiwan, Tajikistan, Tanzania-UR, Thailand, Timor-Leste, Togo, Trinidad & Tobago, Tunisia, Turkey, Turkmenistan, Tuvalu, Uganda, Ukraine, Uruguay, Uzbekistan, Vanuatu, Venezuela, Vietnam, Yemen, Zambia, Zimbabwe Based on WHO Global TB Report 2014

Testing and chest x-ray MUST be done within 6 months prior to the start of school.

4A. TB BLOOD TEST OR→	4B. TB SKIN TEST (PPD)	4C. CHEST X-RAY Is only accepted/required for past or current positive TB skin or blood test.	4D. MEDICATION TREATMENT
☐ Quantiferon ☐ T-Spot	Date Planted: _____ MM/DD/YYY	Not required if completed treatment for TB	☐ Latent TB Infection ☐ Active TB Infection
Date:_____ MM/DD/YYYY	Date Read: _____ MM/DD/YYYY		
Result ☐ NEG ☐ POS ☐ Indeterminate	Interpretation (If no induration, mark 0) ☐ NEG ☐ POS	Chest X-ray Date:_____ MM/DD/YYYY	Date:_____ MM/DD/YYYY
Recommended for prior BCG	mm. of induration _____	☐ Normal ☐ Abnormal	List Medication

NON-Required Vaccinations

Hepatitis B #1	Hepatitis B #2	Hepatitis B #3	Hepatitis B Titer Result
Date:	Date:	Date:	Date: ☐ POS ☐ NEG

HPV Vaccination #1	HPV Vaccination #2	HPV Vaccination #3	Tetanus ☐ Tdap ☐ Td	Meningococcal Group B Vaccine (TRUMENBA, BEXSERO)
Date:	Date:	Date:	Date:	Date series completed:

Clinician Signature

[Signature is required to validate the immunization information] Date:

Physical Examination Affirmation: I have examined this patient on _____ and find no medical condition that would prohibit him/her from participating fully in all activities including physical education, trying out for competitive sports or military training and employment.

Clinician Signature NOTE: A physical exam is not a requirement for entry.

Consent for treatment required to be signed (If you are less than 18 years of age signatures of both the student and one parent/guardian are required)

I hereby grant permission for the University of Connecticut Health Services staff to provide me with appropriate medical and mental health treatment including medications for treatment of illnesses/injuries and to arrange for any emergency medical care if circumstances at that time make it impossible for me to make such decisions. Furthermore, I understand that Student Health Services staff may disclose my student 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 Services staff.

(If student under 18 years old)

Signature of Student Signature of Parent/Guardian Date:

www.shs.uconn.edu PHONE: 860-486-4700 FAX: 860-486-5300

Last Name	First	Net ID
Home/Personal Email Address	Student Cell Phone	

Permanent Home Information		Notify in Case of Emergency	
Home Phone	Cell/Work Phone	Name	Relationship
Street Address		Home Phone	Cell/Work Phone
City	State Zip	Street Address	
		City	State Zip

Personal Physician/Healthcare Provider		Address	
Name			
Telephone #	FAX #	City	State Zip

Allergies: Drugs & Other Severe Adverse Reactions **- Please list all that apply and explain reaction** ☐ **Check if you have no allergies**

Medication	Reaction:	Food	Reaction:
		Environmental	Reaction:
Insect	Reaction:	X-ray Contrast	Reaction:

Are any of these *life threatening?* ☐ **Yes** ☐ **No**
List if yes.

Do you carry an Epi Pen? ☐ **Yes** ☐ **No**
List reason if yes.

Personal Medical & Mental Health History/Disorder/Problem **- Circle all that apply** ☐ **Check if none apply to you**

ADHD	**Coagulation**	**GYN**	**Seizures**
Alcohol/drug abuse	**Depression**	**Hepatitis B or C**	**Sickle cell anemia**
Anxiety	**Diabetes Type I**	**High blood pressure**	**Skin**
Asthma	**Diabetes Type II**	**HIV/AIDS**	**Thyroid**
Cancer	**Eating Disorder**	**Migraine**	**Other please explain below**
Cardiac condition/heart murmur	**Gastrointestinal**	**Musculoskeletal**	

Explain any of the items that you have circled above or if there are any significant medical or mental health conditions for which you seek healthcare. Attach any additional information to further explain your condition or concern.

In addition, we offer a free New Student appointment for Storrs students if you wish to discuss any medical condition where we can collaborate with your primary care provider. Call 860-486-2719 for additional information. While we collect information about your health history, it is ultimately up to you to initiate contact or treatment planning once you have arrived at the Storrs campus.

Prior Hospitalizations, Surgeries or Orthopedic Procedures – List dates and reasons

Medications – List all medications; prescriptions, and over the counter medications and supplements that you <u>currently</u> take.

Current Height: Current Weight:

_____
initial

I consent to receive text messages from UConn Student Health Services at my cell phone number above (and any number/email forwarded or transferred to/from that number.) This may include confirmation of an appointment, test results, or a reminder alert. I understand that this permission will remain in effect unless I request a change in writing.

Did your provider sign and complete the other side? Did you initial the Messaging Consent above?

If you are under 18, a parent or guardian must sign the Consent for Treatment on Page 1.

<u>Don't forget to make a copy of this form and any attachments for your records!</u>

Mail this form and any attachments to:
UCONN SHS, Medical Records, U-4011, 234 Glenbrook Rd, Storrs, CT 06269
Or use the enclosed postage paid envelope that is mailed to UCONN Student Health Services' mail center.