UCONN
UNIVERSITY OF CONNECTICUT

Clinical Rotation Health Review Form

Part 1: To be completed by Student

LAST NAME	FIRST NAME	MI	Date of Birth

PeopleSoft ID #	Email @uconn.edu	Cell or Local Phone

Program

☐ Allied Health Sciences ☐ Athletic Training ☐ Nursing ☐ Pharmacy ☐ Physical Therapy ☐ Psych/Clinical Psychology
☐ Social Work ☐ Speech & Hearing

CAMPUS ☐ Avery Point ☐ Hartford ☐ Stamford ☐ Storrs ☐ 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

Any questions concerning your requirements and submission deadlines should be directed to your Program Contact listed here:

Allied Health Sciences (including Dietetics, Medical Laboratory Sciences & Diagnostic Genetic Sciences)
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Storrs, CT 06269-1101
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Physical Therapy & Athletic Training
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Psychology/Clinical Psychology
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Social Work
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Speech, Language, and Hearing Sciences
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slhs@uconn.edu

*CONTINUE TO **PART 2** FOR IMMUNIZATION HISTORY►►►►*

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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.

→ **IgG Titers** for ☐ Measles, ☐ Mumps, ☐ Rubella, ☐ Varicella, ☐ Hepatitis B, ☐ Polio

A copy of the lab results must accompany this form. Tests done at UConn SHS can be obtained by going to http://shs.uconn.edu/request-personal-health-info/

Last Name	First Name	MI	PeopleSoft ID #

DISEASE	PEDIATRIC VACCINATION 1 DATE	PEDIATRIC VACCINATION 2 DATE	IgG TITER DATE	TITER RESULTS (Immune = Positive)
MEASLES	/ /	/ /	/ /	☐ IMMUNE ☐ NON-IMMUNE*
MUMPS	/ /	/ /	/ /	☐ IMMUNE ☐ NON-IMMUNE*
RUBELLA	/ /	/ /	/ /	☐ IMMUNE ☐ NON-IMMUNE*
VARICELLA	/ /	/ /	/ /	☐ IMMUNE ☐ NON-IMMUNE*
POLIO	1ST O/IPV DATE / / ; 2ND O/IPV DATE / /	3RD O/IPV DATE / / ; BOOSTER DATE / /	/ /	☐ IMMUNE ☐ NON-IMMUNE*
*HEPATITIS B***	1ST HEP B DATE / / ; 2ND HEP B DATE / /	3RD HEP B DATE / /	/ /	☐ IMMUNE ☐ NON-IMMUNE*

***NOTE: Negative immune response to the diseases listed above may require boosters, repeat immunization(s) and/or repeat blood tests. STUDENTS are responsible for scheduling follow-ups to satisfy the clinical requirement. Supplemental or repeat vaccination(s)/titer(s) documentation should be provided separately.**

TETANUS BOOSTER **(Must have been given within the past 10 years)**
Tetanus, diphtheria & pertussis is the current preferred vaccination for all entering clinical sites.

☐ Tdap ☐ Td DATE: / /

INFLUENZA VACCINATION (***between October & March of every calendar year***):

DATE: / / Brand Name:

Lot # Exp. Date: : / /

TUBERCULOSIS: Either IGRA/BAMT blood test or tuberculosis skin test (TST)/ PPD (*below*).	IGRA/BAMT Blood test, either: ☐ Quantiferon ☐ T-Spot	IGRA/BAMT Date: / /	Result: ☐ Negative ☐ Positive ☐ Indeterminate

TST/ PPD	DATE PLANTED:	DATE READ: / / mm _____	RESULTS: ☐ Negative ☐ Positive	2nd TST/PPD (when a 2- Step PPD is required)	DATE PLANTED: / /	DATE READ: / / mm _____	RESULTS: ☐ Negative ☐ Positive

If Positive, Chest x-ray is needed *X-RAY DATE:* / / *RESULTS:*	HX of TB Treatment and Completion Date (Specify type):	Use this section to note immunization concerns (i.e. non converter, BCG vaccinated):

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:** _____

Rev 12/15/2017

*CONTINUE TO **PART 3** FOR THE MANDATORY PHYSICAL EXAM►►►►*

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Part 3: Physical Examination to be completed by Healthcare Provider. (Please fill out form completely.)

Last Name	First Name	MI	PeopleSoft ID #

Vital Signs				Date of Birth
BP:	Pulse:	Height:	Weight:	

WNL	*Check Box for findings within normal limits*
	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 (Required)

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:** _____