### Consent for Treatment

I hereby grant permission for the University of Connecticut Student 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. I understand that SHS may disclose information from my medical records to appropriate University personnel and/or family members and/or my Emergency Contacts in the case of a health or safety situation as deemed necessary by SHS staff. Further, I understand that Student Health Services staff may disclose my medical records and/or information from such records to appropriate University personnel for purposes of treatment, payment and healthcare operations, and hereby consent to all such disclosures.

**Student Signature:**

**Date:**

---

### Immunization History

In lieu of a provider’s signature, your certified immunization records are acceptable.

**NOTE:** For MMR and Varicella vaccinations, the 1st dose must be after your first birthday and the 2nd dose at least 28 days later.

#### 1. Required of all students born after 1956

**Measles-Mumps-Rubella (MMR) Vaccination**

<table>
<thead>
<tr>
<th>Dose #1</th>
<th>Dose #2</th>
<th>Measles Titer</th>
<th>Result</th>
<th>Measles Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM/DD/YYYY</td>
<td>MM/DD/YYYY</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Measles Single Vaccination**

<table>
<thead>
<tr>
<th>Dose #1</th>
<th>Dose #2</th>
<th>Mumps Titer</th>
<th>Result</th>
<th>Mumps Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM/DD/YYYY</td>
<td>MM/DD/YYYY</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Mumps Single Vaccination**

<table>
<thead>
<tr>
<th>Dose #1</th>
<th>Dose #2</th>
<th>Rubella Titer</th>
<th>Result</th>
<th>Rubella Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM/DD/YYYY</td>
<td>MM/DD/YYYY</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Rubella Single Vaccination**

<table>
<thead>
<tr>
<th>Dose #1</th>
<th>Dose #2</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MM/DD/YYYY</td>
<td>MM/DD/YYYY</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 2. Required of all students born after 1979

**Varicella Vaccination**

<table>
<thead>
<tr>
<th>Dose #1</th>
<th>Dose #2</th>
<th>Varicella Titer</th>
<th>Result</th>
<th>Chicken Pox Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM/DD/YYYY</td>
<td>MM/DD/YYYY</td>
<td></td>
<td></td>
<td>MM/DD/YYYY</td>
</tr>
</tbody>
</table>

#### 3. Required of all students living in university housing

**Meningitis Vaccination (MCV4)**

Must cover strains A, C, Y, W-135 (Menactra, Menveo, MievevaX, Nimenrix)

<table>
<thead>
<tr>
<th>Date</th>
<th>Vaccination must have been given within 5 years of your first day of classes at UConn.</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM/DD/YYYY</td>
<td></td>
</tr>
</tbody>
</table>

**Exceptions to requirement:**

- [ ] I will not be living in campus owned housing.
- [ ] I am over 29 years of age.

#### 4. Required of all students

**Tuberculosis (TB) Risk Questionnaire** (Questions 4a. through 4d. to be answered by the student)

- [ ] Yes
- [ ] No

- a) Have you ever had a positive tuberculosis skin or blood test in the past? **If YES, Go to Step 2** (Chest X-ray / Medication sections below)
- b) To the best of your knowledge, have you ever had close contact with anyone who was sick with tuberculosis (TB)?
- c) Were you born in one of the countries listed on page 2 of Form A? **If yes, which country?**
- d) Have you traveled to or lived for more than one month in one or more of the countries listed? **If yes, which country?**

**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. Please see Step 1**

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.

**Healthcare provider must document test results below. All Testing and Chest X-ray (if required) must be within 6 months prior to the start of school.**

<table>
<thead>
<tr>
<th>STEP 1: TB Blood Test/IGRA</th>
<th>OR</th>
<th>SKIN TEST (PPD)</th>
<th>STEP 2: CHEST X-RAY</th>
<th>OR</th>
<th>MEDICATION TREATMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommended if prior BCG</strong></td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>[ ] Quantiferon</td>
<td>[ ] T-Spot</td>
<td>Date Planted:</td>
<td>Date Read:</td>
<td>Interpretation:</td>
<td></td>
</tr>
<tr>
<td>[ ] NEG</td>
<td>[ ] POS</td>
<td>mm of induration:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**IF Positive, Proceed to Step 2**

- [ ] Latent TB Infection
- [ ] Active TB Infection

**Date(s):**

List Medication(s):
5. STRONGLY RECOMMENDED VACCINATIONS

<table>
<thead>
<tr>
<th>Vaccination Name</th>
<th>Dose #1: MM/ DD / YYYY</th>
<th>Dose #2: MM/ DD / YYYY</th>
<th>Dose #3: MM/ DD / YYYY</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEPATITIS A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HEPATITIS B</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HUMAN PAPILLOMAVIRUS (HPV)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MENINGOCOCCAL SEROGROUP B</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TETANUS, DIPHTHERIA, PERTUSSIS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. REQUIRED OF ALL NCAA STUDENT-ATHLETES ONLY

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.

Date of Last Physical Exam (MM/DD/YYYY): ______ / ______ / _______

X ___________ 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.

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

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bahamas
Bangladesh
Belize
Benin
Bhutan
Bolivia
Bosnia and Herzegovina
Botswana
Brazil
Brunei
Burundi
Cambodia
Cameroon
Cape (Cabo)
Verde

Central African
Chad
China
China, Hong Kong
Kong
China, Macao
Colombia
Comoros
Congo
Côte d'Ivoire
Democratic
People’s Republic of
of Korea
Democratic
Republic of the
Congo
Dominican
Republic
Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Ethiopia
French Polynesia
Fiji

Gabon
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iran
Iraq
Ireland
Iran
Islamic Republic of
Kenya
Kiribati
Kuwait
Kyrgyzstan
Laos PDR
Latvia
Lesotho
Liberia
Libyan Arab
Jamahiriya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Mauritania
Mauritius
Mexico
Micronesia
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Northern Mariana
Islands
Niue
Pakistan
Palau
Panama

Papua New Guinea
Paraguay
Peru
Philippines
Portugal
Qatar
Korea
Moldova
Romania
Russian Federation
Sao Tome and Principe
Senegal
Sierra Leone
Singapore
São Tomé and Principe
Somalia
South Africa
South Sudan
Suriname
Swaziland
Tajikistan
Thailand
Timor-Leste
Togo
Turkmenistan
Tuvalu
Uganda
United Arab Emirates
Ukraine
United Kingdom
United Republic of
Tanzania
Uzbekistan
Uruguay
Vietnam
Venezuela
Viet Nam
Yemen
Zambia
Zimbabwe
**University of Connecticut 2018-2019 Student Health History – Form B**

**FORM B DOES NOT NEED TO BE SCANNED AND UPLOADED. IT IS FOR YOUR REFERENCE TO ASSIST WITH COMPLETING AN ELECTRONIC VERSION WHEN YOU LOG INTO MYHEALTH.UCONN.EDU TO UPLOAD FORM A.**

<table>
<thead>
<tr>
<th>Student Last Name</th>
<th>Student First Name</th>
<th>Student Middle Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth: MM/DD/YYYY</th>
<th>Sex Assigned at Birth:</th>
<th>Gender Identity:</th>
<th>Net ID</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Permanent Home Information**

<table>
<thead>
<tr>
<th>Student’s Preferred E-mail Address</th>
<th>Name</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Student’s Cell Phone</th>
<th>Home Phone</th>
<th>Home Phone</th>
<th>Cell/Work Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Address</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

**Notify in Case of Emergency**

- By initialing, I consent to receive text messages from UConn Student Health Services at my cell phone number above (and any number/e-mail 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.

**Personal Physician/Healthcare Provider**

- Name
- Address
- PHONE #
- FAX #

**MEDICATIONS** – List all medications; prescriptions, and over the counter medications and supplements that you currently take.

**ALLERGIES: Drugs and other Severe Adverse Reactions**

- List all that apply and explain reaction
- Check if you have no allergies

<table>
<thead>
<tr>
<th>Medication Allergies</th>
<th>Drug Name</th>
<th>Reaction</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Food Allergies</th>
<th>Reaction</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>X-ray Contrast</th>
<th>Reaction</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Insect(Bee/Wasp stings)</th>
<th>Reaction</th>
</tr>
</thead>
</table>

- Are any of these life threatening? Yes No
- If yes, list reasons

- Do you carry an Epi Pen? Yes No
- If yes, list reasons

**MEDICAL & MENTAL HEALTH HISTORY**

- Circle all that apply
- Check if none apply to you

<table>
<thead>
<tr>
<th>ADHD</th>
<th>Alcohol/drug abuse</th>
<th>Anxiety</th>
<th>Asthma</th>
<th>Blood clotting disorder</th>
<th>Cancer</th>
<th>Cardiac condition/heart murmur</th>
<th>Crohn's disease</th>
<th>Depression</th>
<th>Diabetes</th>
<th>Eating Disorder</th>
<th>Hepatitis B</th>
<th>Hepatitis C</th>
<th>HIV/AIDS</th>
<th>Immunocompromised</th>
<th>Organ Transplant</th>
<th>Rheumatoid arthritis</th>
<th>Seizure disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Sickle cell anemia</th>
<th>Ulcerative Colitis</th>
<th>Other (please list)</th>
</tr>
</thead>
</table>

**Explain** below for all of the items that you circled above. Please explain other significant medical or mental health conditions for which you seek healthcare. Attach any additional information to further explain your condition or concern.

**Prior Hospitalizations, Surgeries or Orthopedic Procedures**

- List dates and reasons

<table>
<thead>
<tr>
<th>Current Height:</th>
<th>Current Weight:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Storrs students who wish to further discuss coordination of healthcare needs for ongoing medical and/or mental health concerns may contact Student Health Services by calling 860-486-2719, or Counseling and Mental Health Services by calling 860-486-4705 for a free New Student appointment. While we collect health information, it is ultimately up to you to initiate contact and/or treatment planning with our services.