Dear New UConn Student:

Congratulations on your acceptance! We look forward to meeting you and working with you to maintain your health while at UConn. Our mission at Student Health Services is to promote the lifelong physical and emotional well-being of our students. We believe that a healthy Husky will be a successful Husky!

One of our responsibilities is to ensure that each matriculating student complies with State of Connecticut immunization laws as well as university health requirements.

There are 3 Health-related Requirements at UConn:

A. Immunization and Consent Form
B. Medical History
C. Health Insurance

To meet these requirements:

1. Please review the enclosed instructions and complete the forms provided. Forms A and B need to be completed on-line in accordance with the deadlines mentioned below. Form A must be uploaded to our patient portal at myHealth.uconn.edu along with any certified immunization records from your health care provider, and
   * NCAA Athletes ONLY: All NCAA student athletes MUST provide proof of their Sickle Cell Trait (SCT) status prior to participating in any athletic activities at UConn.
   * Club Sport Athletes: All Club Sports athletes must be medically cleared to play prior to participation. Students intending to participate in Club Sports must have the signature of their healthcare provider (see page 2 of Form A) verifying that they have had a physical examination within one year of the season(s) start date.

2. Complete the on-line Insurance Waiver in www.studentadmin.uconn.edu if you do not want to enroll in the UConn Student Health Insurance Plan.

Deadlines:

* Forms A and B – July 2 for Fall matriculation and January 2 for Spring matriculation.
* Insurance Waiver – September 15 for Fall matriculation and February 5 for Spring matriculation.

If you need any assistance, please contact us at 860-486-4700 or shs@uconn.edu.

Again, please accept our warm welcome as well as our best wishes for your future success!

Suzanne A. Onorato, Ph.D.
Executive Director, Student Health Services
Immunizations
Per Connecticut State Statute, these must be completed prior to coming to campus:

- MMR (Measles, Mumps and Rubella) – If you were born after 12/31/1956, you must provide proof of one of the following:
  - TWO doses of MMR vaccine (one after your first birthday and one at least 28 days later), OR
  - TWO doses each of the separate Measles, Mumps and Rubella vaccines (the first dose must be after your first birthday and the second dose at least 28 days later.)
- Varicella (Chicken Pox) – If you were born after 12/31/1979, you must provide proof of TWO varicella immunizations (one after your first birthday and one at least 28 days later.)
- Meningitis – Students living in university-owned housing must provide proof of having received one dose of Meningococcal A,C,Y,W-135 conjugate vaccine that was administered not more than 5 years before enrollment.

If you are unable to obtain proof of vaccination, your healthcare provider may order Lab tests (titers) and submit results that confirm immunity, or your provider may certify that you have had the disease(s) and are thereby immune.

The immunization history must be signed by a physician, nurse practitioner or physician’s assistant. In lieu of a provider signature, you may attach certified immunization records from previous school, health care provider or government agency.

Students in health-related professional programs may be required to submit additional health history information as outlined by their clinical program.

The only circumstances under which a student may be exempt from submitting proof of immunizations are as follows:

- A physician certifies that a medical condition precludes immunization.
- The student states in writing that the required immunizations would conflict with his/her religious beliefs.

If either of these exemptions exist, Exemption forms are available on our website shs.uconn.edu/forms

In the event of a campus infectious disease exposure or outbreak, students who have not received the required vaccines may be required to leave campus during the period of contagion.

The following immunizations are not required but are strongly recommended:

- Hepatitis B
- Human Papillomavirus
- Meningococcal serogroup B
- Tetanus, Diphtheria, Pertussis (Tdap or Td)

About Health History Forms A & B
Forms A and B must be completed via online patient portal at myHealth.uconn.edu

1. Form A is the written Consent and Immunization History.
   Take this form to your healthcare provider who will document your immunization history and sign the form. Certified immunization records from your healthcare provider are also accepted.

   Parental consent is required for all students under the age of 18. This consent is found on Form A.

2. Form B is your Medical History that will be required to be completed online. This info will help us provide care if you are a student at the Storrs campus.

3. Log into the patient web portal at myHealth.uconn.edu. Select “My Forms” and enter the information from Forms A and B. Scan and upload Form A plus any other supporting documents.

Complete/upload both forms by August 2 for the Fall semester or January 2 for Spring semester.

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

ALL students at ALL campuses must submit their MANDATORY immunization information to us via the Health History Form that is available at www.shs.uconn.edu/forms. Students will be notified via their UConn email as to their current compliance standing. Student Health Services maintains a web portal through which you may view your immunization information once we have entered it. To use the web portal:

1. Go to myhealth.uconn.edu
2. Log in using your NetID and password
3. Hover over My Profile and a menu will drop down
   4. Select Immunization History
   5. You can save and/or print the report that is displayed by using the appropriate icons.

(Note: the portal only works with IE9 or higher, Firefox, Chrome and Safari browsers)

Insurance Information 2018-2019

DEADLINES: Fall Semester September 15th (Waiver available June 1st to September 15th)
Spring Semester February 5th (Waiver available December 1st to February 5th)

It is a university policy that all full time*, degree seeking students are required to maintain medical insurance coverage, for protection in the event of accident or illness.

Most full time* students are AUTOMATICALLY enrolled and billed for the university sponsored medical insurance plan. If you want to be enrolled in the university plan and you have been billed for the premium, no action is required. You will be reported to the carrier as active/enrolled for the full plan year (8.15.18 to 8.14.19).

While most full-time* students are automatically billed for the Insurance, there are some university programs that are exempt from the medical insurance requirement. It is advised that ALL students check their tuition fee bill to determine whether the fee for the insurance has been posted (the charge appears as a separate line item “Health Insurance” under “Term” charges).

Part time students, while not automatically billed, are eligible to voluntarily enroll in the plan. Students that elect to voluntarily enroll in the plan should contact the university Insurance Coordinator at 860.486.4535.

Visit shs.uconn.edu/insurance-information to learn more about the university-sponsored plan coverage, premiums and limits. Or contact the Bailey Agencies at 1-800-321-4449 or online at www.baileyagencies.com

If a student has other insurance coverage and does not need the plan offered by the university, an on-line insurance waiver must be completed by the beginning of the fall semester of every academic year.

The online waiver is the only acceptable method to decline or “waive” the insurance plan

To access the online waiver in the UConn Student Administration (PeopleSoft) system, the student will need their UConn Net ID and their secure password.

- Log on to www.studentadmin.uconn.edu
- Navigate to Self Service > Student Center
- Scroll down to the “Finances” section of the Student Center
- Click on “Create Student Permissions”
- The UConn Student permissions page displays
- Click on “Health Insurance Waiver” and complete the form

NOTE: for new students, the “FERPA” waiver (also found on the student permissions page) must be completed before access to the insurance waiver is allowed.

Upon completion of the form an electronic sign off is required. To sign off “sign” using your Net ID number. Then click on “Submit”. Once you’ve submitted the form a pop up message “Waiver Successfully Created” should appear. That is your confirmation that the waiver processed.

No matter which insurance plan students are covered by, students should always bring their current medical and prescription card(s) as well as their student ID to each visit at

* A full-time student is defined as a degree seeking undergard enrolled for 12 or more credits, or a graduate student enrolled for 9 or more credits.

FOR MORE INFORMATION ABOUT STUDENT HEALTH AND WELLNESS SERVICES

<table>
<thead>
<tr>
<th>Counseling &amp; Mental Health</th>
<th>Student Health (Medical)</th>
<th>Wellness &amp; Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>337 Mansfield Road, U-1255</td>
<td>234 Glenbrook Road, U-4011</td>
<td>626A Gilbert Road, U-1059</td>
</tr>
<tr>
<td>Storrs, CT 06269-1255</td>
<td>Storrs, CT 06269-4011</td>
<td>Storrs, CT 06269-1059</td>
</tr>
<tr>
<td>860-486-4705</td>
<td>860-486-4700</td>
<td>860-486-9431</td>
</tr>
<tr>
<td>counseling.uconn.edu</td>
<td>shs.uconn.edu</td>
<td>wellness.uconn.edu</td>
</tr>
</tbody>
</table>
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: __________________________ Parent/Guardian Signature: __________________________ Date: __________________________

If you are under the age of 18 years old, your parent/guardian must sign.

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

Date #1: [MM/DD/YYYY]  Date #2: [MM/DD/YYYY]  A titer showing immunity to OR incidence of each individual disease is an acceptable alternative to vaccination. Please document in the appropriate area below. (month/day/year)

Measles Titer  Result  Measles Disease

OR

Measles Single Vaccination

Dose #1: [MM/DD/YYYY]  Dose #2: [MM/DD/YYYY]  Measles Titer  Result  Measles Disease

OR

Measles Disease

AND

Mumps Single Vaccination

Dose #1: [MM/DD/YYYY]  Dose #2: [MM/DD/YYYY]  Mumps Titer  Result  Mumps Disease

OR

Mumps Disease

AND

Rubella Single Vaccination

Dose #1: [MM/DD/YYYY]  Dose #2: [MM/DD/YYYY]  Rubella Titer  Result  Rubella Disease

OR

Rubella Disease

2. REQUIRED OF ALL STUDENTS BORN AFTER 1979

VARICELLA VACCINATION

Date #1: [MM/DD/YYYY]  Date #2: [MM/DD/YYYY]  Varicella Titer  Result  Chicken Pox Disease

OR

Varicella Disease

3. REQUIRED OF ALL STUDENTS LIVING IN UNIVERSITY HOUSING

MENINGITIS VACCINATION (MCV4)

Must cover strains A, C, Y, W-135 (Menactra, Menevo, Mecevax, Nimenrix)

Date: [MM/DD/YYYY]  Vaccination must have been given within 5 years of your first day of classes at UConn.

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)

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)  ☐ 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 on page 2 of Form A?  If yes, which country?  ☐ Yes  ☐ No

d) Have you traveled to or lived for more than one month in one or more of the countries listed?  If yes, which country?  ☐ Yes  ☐ No

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.

STEP 1: TB Blood Test/IGRA

OR

SKIN TEST (PPD)

Recommended if prior BCG

☐ Quantiferon  ☐ T-Spot

Date: __________________________

Result:  ☐ NEG  ☐ POS

STEP 2: CHEST X-RAY

OR

MEDICATION TREATMENT

Required if past or current positive TB skin or blood test.

Not required if completed treatment for TB

Chest X-ray Date: __________________________

☐ Latent TB Infection  ☐ Active TB Infection

Date(s): __________________________

List Medication(s): __________________________
5. STRONGLY RECOMMENDED VACCINATIONS

HEPATITIS A
- Dose #1: [MM/DD/YYYY]
- Dose #2: [MM/DD/YYYY]

HEPATITIS B
- Dose #1: [MM/DD/YYYY]
- Dose #2: [MM/DD/YYYY]
- Dose #3: [MM/DD/YYYY]

HUMAN PAPILLOMAVIRUS (HPV)
- HPV4
- HPV9

MENINGOCOCCAL SEROGROUP B
- MenB
- MenB-4C

TETANUS, DIPHTHERIA, PERTUSSIS
- Date of Last Physical Exam (MM/DD/YYYY): _____ / _____ / ________
- Provider initial: __________
- Tdap
- Td

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
Belarus
Belize
Benin
Bhutan
Bolivia
Bosnia and Herzegovina
Botswana
Brazil
Brunei
Burkina Faso
Burundi
Cambodia
Cameroon
Cape (Cabo)
Central African Republic
Chad
China
China, Hong Kong
China, Macao
Colombia
Comoros
Congo
Côte d'Ivoire
Democratic People's Republic of Korea
Democratic Republic of the Congo
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Ethiopia
French Polynesia
Fiji
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Ireland
Ireland
Israel
Italy
Jamaica
Japan
Jordan
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Laos PDR
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nepal
Nicaragua
Niger
Nigeria
Northern Mariana Islands
Norway
Oman
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Sao Tome and Principe
Saudi Arabia
Senegal
Sierra Leone
Singapore
Slovakia
Somalia
South Africa
Sri Lanka
Sudan
Suriname
Swaziland
Tajikistan
Thailand
Timor-Leste
Togo
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Venezuela
Vietnam
Zambia
Zimbabwe
**Student Last Name** | **Student First Name** | **Student Middle Name**
--- | --- | ---
Date of Birth: | Sex Assigned at Birth: | Gender Identity: | Net ID

**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>Student’s Cell Phone</td>
<td>Home Phone</td>
<td>Home Phone</td>
</tr>
<tr>
<td>Home Address</td>
<td>Address</td>
<td></td>
</tr>
</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**

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHONE #</td>
<td>FAX #</td>
</tr>
</tbody>
</table>

**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>Drug Name</th>
<th>Reaction</th>
<th>Food Allergies:</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>X-ray Contrast</td>
<td>Reaction:</td>
<td>Insect(Bee/Wasp stings)</td>
<td>Reaction:</td>
</tr>
</tbody>
</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

| ADHD | Cardiac condition/heart murmur | Hepatitis C | Sickle cell anemia |
| Alcohol/drug abuse | Crohn's disease | HIV/AIDS | Ulcerative Colitis |
| Anxiety | Depression | Immunocompromised | Other (please list) |
| Asthma | Diabetes | Organ Transplant | |
| Blood clotting disorder | Eating Disorder | Rheumatoid arthritis | |
| Cancer | Hepatitis B | Seizure disorder | |

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

| Current Height: | Current Weight: |

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