**IMMUNIZATION HISTORY**

1. **MEASLES, MUMPS, RUBELLA (MMR) Vaccination** - required of all students born after 1957

   **OPTION 1:** Measles, Mumps, Rubella (MMR) Vaccination
   (First dose must be given on or after your first birthday to be accepted)
   - **Dose #1:** MM/DD/YYYY
   - **Dose #2:** MM/DD/YYYY

   **OPTION 2:** In lieu of proof of vaccination above, a titer showing immunity to each individual disease is an acceptable alternative to the vaccination.
   - **Measles Titer Result:**
     - Immune
     - Not immune
   - **Date:** MM/DD/YYYY
   - **Mumps Titer Result:**
     - Immune
     - Not immune
   - **Date:** MM/DD/YYYY
   - **Rubella Titer Result:**
     - Immune
     - Not immune
   - **Date:** MM/DD/YYYY
   *If not immune, you are required to receive a booster MMR and repeat the titer or receive two MMR vaccines in lieu of the booster and titer

   **OPTION 3:** An incidence of disease will take the place of a vaccine requirement. (Must be filled in by a physician/APRN/PA)
   - **Measles Disease:** MM/DD/YYYY
   - **Mumps Disease:** MM/DD/YYYY
   - **Rubella Disease:** MM/DD/YYYY

2. **VARICELLA** Vaccination - required for all students born after 1979

   **OPTION 1:** Varicella Vaccination
   (First dose must be given on or after your first birthday to be accepted)
   - **Dose #1:** MM/DD/YYYY
   - **Dose #2:** MM/DD/YYYY

   **OPTION 2:** In lieu of proof of vaccination above, a titer showing immunity to the disease is an acceptable alternative to the vaccination.
   - **Varicella Titer Result:**
     - Immune
     - Not immune
   - **Date:** MM/DD/YYYY
   *If not immune, you are required to receive a booster and repeat the titer or receive two Varicella vaccines in lieu of the booster and titer

   **OPTION 3:** An incidence of disease will take the place of a vaccine requirement. (Must be filled in by a physician/APRN/PA)
   - **Varicella Disease:** MM/DD/YYYY

3. **MENINGOCOCCAL (MCV4) Vaccination** - Required of all students living in University housing

   - ☐ Menactra
   - ☐ Menveo
   - ☐ Nimenrix
   - Must cover strains A, C, Y, W-135
   - Polysaccharide strain not accepted
   - **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. **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.

5. **SICKLE CELL TRAIT TEST** - 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 be uploaded to your Student Health Portal.

---

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

*By signing below, I am certifying the accuracy of the information documented on the Student Health History Form.*

Signature_________________________ Date________________ Phone________________

Name (print): ____________________________ Address: ___________________________

NPI#: _______________________________
Student Health and Wellness Consents

Consent for Treatment:
I hereby grant permission for the University of Connecticut Student Health and Wellness staff to provide me with appropriate medical and mental health treatment including medication 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 Student Health and Wellness may disclose information from my medical records to appropriate University personnel and/or family members and/or Emergency contacts in the case of a health or safety situation as deemed necessary by Student Health and Wellness staff.

I understand that Student Health and Wellness 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 such disclosures.

Insurance Release:
UConn Student Health and Wellness will provide insurance claim processing for qualified students/patients under these terms:

Claims will be filed for the following insurance carriers: Aetna, Anthem Blue Cross Blue Shield, CIGNA, ConnectiCare, CT Medicaid, Tricare, and United Healthcare. Claims for other insurance carriers will not be processed. Charges for services provided to students with non-participating plans will be placed on the student's fee bill. Upon request, Student Health and Wellness will provide documentation for personal filing purposes.

THE STUDENT IS RESPONSIBLE FOR PRE-AUTHORIZATION OR REFERRAL IF REQUIRED BY THEIR INSURANCE PLAN. (Call the phone number on your insurance card before receiving services to determine if covered by your plan)

By signing below, I authorize Student Health and Wellness to submit to my insurance and agree to take responsibility for all charges whether or not paid by insurance. I acknowledge that my PeopleSoft account may be put "on hold" for unpaid charges incurred at Student Health and Wellness.

Signature(s) below indicates understanding of an agreement with the above information.

Student Signature:  X  Date:  
Parent/Guardian Signature:  X  Date:  

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