Name: ______________ **DOB:** __________ **PeopleSoft #:** __________ **Program:** __________________

Clinical/Field Placement Student Health Record

Important First Step: Make an appointment with your Primary Care Provider ASAP - Your clinical or field program requires that you have a physical examination, which likely means making an appointment with a healthcare provider. These appointments can sometimes be difficult to schedule, so please plan ahead! You may also be able to schedule a physical at UConn Student Health & Wellness (SHaW), depending on the time of year and your insurance.

This packet outlines the health requirements you'll have to fulfill to participate in clinical and/or field experiences. The information and forms in this packet will help you understand what you need to do over the coming weeks to stay on track. **Should you have any questions, please don't hesitate to reach out to ocpc.compliance@uconn.edu for assistance!**

The most important thing to keep in mind is that participation in any clinical or field training experiences may happen ONLY when you have satisfied all clinical requirements!

Helpful tips…

1. **Complete these requirements as soon as possible**, following your program's guidance and deadlines. Remember that some requirements can take time to complete due to waiting periods or provider scheduling constraints. Be proactive!
2. **The cost of meeting these requirements is your responsibility** and may not be covered by your health insurance. If you have questions, please reach out to OCPC or your clinical coordinator.
3. **You have options for completing some requirements.** You will likely need to have your physical and titers done through your primary care provider or SHaW. Immunization boosters, PPD tests, and flu shots can be completed at your provider or SHaW, but can also be done at most pharmacies and travel clinics.
4. **Positive titers are required for MMR, Varicella, and Hepatitis B; proof of past immunization is not sufficient for compliance.** Positive titers demonstrate immunity; negative or equivocal titers indicate a lack of immunity and will require repeat dosing and a repeat titer.
5. **Signatures & Other Required Information:** Make sure to fill out the top section (name, DOB, PeopleSoft#, and program) on each page of this packet or your documents will not be accepted. Additionally, make sure your provider signs all pages as required. In general, lab reports, results, and other documents cannot be handwritten.
6. **These clinical requirements are separate from any paperwork you may have completed or will be completing for Student Health & Wellness upon entry to UConn**.

What's required on my documents and how do I submit them?

1. You'll submit all of your documents through your American DataBank/Complio profile at adb.uconn.edu (account is automatic, simply log in with your netID and password). Documents will then be reviewed by ADB personnel and approved or rejected (usually within 2-3 business days).
2. To be approved, all documents must be clearly legible and include:
   a. Your name
   b. Healthcare provider name
   c. Date performed
   d. For lab results, report must include ***quantitative results*** and reference range(s)
3. **Submit each step as you go and do not wait until you have completed all requirements to submit your documentation!** This will allow your program and OCPC to know where you are in the process and provide assistance along the way.

Name: ______________ **DOB:** ___________ **PeopleSoft #:** ___________ **Program:** __________________

Checklist of Clinical Health Requirements

PART 1 – Physical Examination *(page 1)*

☐ **Physical Exam** – You must have a physical examination **using the provided form** (alternative formats not acceptable).

To Do	☐ Schedule appointment for a physical exam with your healthcare provider, letting them know that you have a specific form that will need to be filled out. ☐ Review sections and make sure you understand what is required for your program: ◻ Vital Signs (required for all programs unless exam is conducted via telehealth) ◻ Normal/Abnormal for Each Area (required for all programs) ◻ Color Vision Screening (required for all Allied Health Sciences and Nursing programs) ◻ N95 Fit Test Clearance (required for all programs; Note: Fit test not required, just clearance)
To Submit	☐ Completed and signed page 4 of this packet ☐ Please make sure all sections are completed except if marked "optional" or not required for program
Follow Up Steps	If your color vision screening is marked as deficient or if your provider lists any limitations, please contact your clinical/field placement director/coordinator to receive guidance about next steps.

PART 2 – Immunization History & Titers *(pages 2-3)*

☐ **MMR** – Demonstrate immunity to Measles, Mumps, & Rubella via **positive quantitative IgG titers**.

To Do	☐ Schedule appointment for your Primary Measles, Mumps, and Rubella IgG titers
To Submit	☐ [Optional] Completed pages 5-6 of this packet showing MMR titer results and any boosters ☐ Titer labwork showing quantitative titer results and reference ranges
Follow Up Steps	If one or more of your primary titers is negative or equivocal: 1. Begin repeat immunization series with MMR booster & submit booster document to Complio 2. Your provider may recommend two boosters; follow guidance and submit documents 3. Schedule needed repeat MMR IgG titer(s) on appropriate schedule and submit labwork If you've completed steps 1-3 above and any repeat titer is negative or equivocal: 1. Have your doctor complete a non-responder form and submit in Complio 2. Contact your clinical/field placement director/coordinator to receive guidance about next steps.

☐ **Varicella** – Demonstrate immunity to Varicella via a positive **quantitative Varicella IgG titer**.

To Do	☐ Schedule appointment for your Primary Varicella IgG titer
To Submit	☐ [Optional] Completed pages 5-6 of this packet showing Varicella titer result & any boosters ☐ Titer labwork showing quantitative titer result and reference ranges
Follow Up Steps	If your primary titer is negative or equivocal: 1. Begin repeat immunization series with Varicella booster & submit booster document to Complio 2. Your provider may recommend two boosters; follow guidance and submit documents as you go 3. Schedule repeat Varicella IgG titer on appropriate schedule and submit labwork If you've completed steps 1-3 above and your repeat titer is negative or equivocal: 1. Have your doctor complete a non-responder form and submit in Complio 2. Contact your clinical/field placement director/coordinator to receive guidance about next steps.

Name: ______________ DOB: ___________ PeopleSoft #: ___________ Program: ________________

PART 2 – Immunization History & Titers continued *(pages 2-3)*

☐ **Hepatitis B** – Demonstrate immunity to Hepatitis B via positive Hepatits B **quantitative surface antibody titer**.

To Do	☐ Schedule appointment for your Primary Hepatitis B titer (HBsAb)
To Submit	☐ [Optional] Completed pages 2-3 of this packet showing Hep B titer result & any boosters ☐ Titer labwork showing quantitative titer result and reference ranges
Follow Up Steps	If your primary titer is negative or equivocal: 1. Begin repeat immunization series with Hep B Booster 1 & submit booster document to Complio 2. Continue with Hep B Boosters 2 & 3 on appropriate schedule, submitting documents as you go 3. Schedule repeat Hep B (HBsAb) titer on appropriate schedule and submit labwork If you've completed steps 1-3 above and your repeat titer is negative or equivocal: 1. Have your doctor complete a non-responder form and submit in Complio 2. Contact your clinical/field placement director/coordinator to receive guidance about next steps.

☐ **Polio** – Required **ONLY** for Nursing programs. Submit previous vaccination records or positive titer.

To Do	☐ Gather previous Polio vaccination records or have provider complete page 6
To Submit	☐ Completed pages 2-3 of this packet or other immunization history document/record. ☐ If previous vaccination record is unavailable, labwork showing positive titer result. If titer is negative, submit documentation showing adult polio booster.

☐ **Tetanus** – You must have a current Tdap vaccination (within 10 years). No titer required. Refer to your specific program for alternate Tetanus requirements.

To Do	☐ Gather previous tetanus vaccination records or have provider complete page 6
To Submit	☐ Completed pages 2-3 of this packet or other immunization history document/record.
Follow Up Steps	Pay attention to your Tetanus expiration date and be sure to have a repeat Tdap immunization if needed to keep current during your full program.

PART 3 – Tuberculosis *(pages 4-5)*

☐ **Tuberculosis** – You must satisfy your program's tuberculosis requirements annually using one of the following options.

To Do	☐ Determine whether you have prior history of TB or history of a positive TB screening test. ☐ If you have **no prior history of TB** or positive TB screening, **select and complete one of these options** in consultation with your healthcare provider and/or program: □ Option A (Preferred) – Blood Test (QuantiFERON Gold or T-Spot) □ Option B – 2-Step Mantoux PPD Skin Test (two PPD tests [plant and read], 7-21 days apart) □ Option C – Baseline Single-Step Mantoux PPD Skin Test *(not acceptable for Allied Health Sciences, Doctor of Physical Therapy, Athletic Training, Nursing, or Psychological Sciences)* ☐ If you have **prior history of TB** and/or positive TB screening, follow these steps: 1. Complete the Annual TB Symptom Screening Questionnaire on page 8 and have your provider sign off that you have completed recommended treatment 2. Gather your most recent chest x-ray results
To Submit	☐ Completed and signed page 4 of this packet or other lab report/documentation of selected test option ☐ If applicable, questionnaire and provider attestation on page 5 of this packet ☐ If applicable, any labwork, chest x-rays, or other documentation

Name: ______________ **DOB:** ___________ **PeopleSoft #:** ___________ **Program:** __________________

PART 1 – Physical Exam

To be completed and signed by healthcare provider. ***All items required unless marked optional.***

VITAL SIGNS

Height: _________ Weight: ___________ Blood Pressure: ______________ Pulse: ___________

CHECK NORMAL/ABNORMAL FOR EACH AREA (if abnormal, please include description)

	Normal	Abnormal	Description of Abnormal Findings
Appearance			
Nutrition			
Skin			
Head/Neck			
Glands			
Eyes			
Ears			
Nose			
Mouth/Teeth/Throat			
Chest			
Lungs			
Heart			
Abdomen			
Back			
Musculo-Skeletal			
Testes (Optional)			
Genitalia/Pelvic (Optional)			
Neurological			
Emotional/Psychological			

COLOR VISION SCREENING (6-plate minimum)

Color Vision screening is required for all Allied Health Sciences & Nursing programs (including Long-Term Care Administration). Optional for other programs. ☐ Normal ☐ Deficient

N95 Respirator Mask Fit Test Clearance

Student is cleared to be fitted for N95 or other respirator mask & to wear it while caring for patients. ☐ Yes ☐ No
Note that a fit test is not required, only clearance for a potential future fit test if necessary.

Healthcare Provider Attestation of Student Fitness for Participation in Clinical Experiences

I have reviewed this student's health history and conducted a physical examination. The information on this form is true and accurate to the best of my knowledge. It is my opinion that this student is in satisfactory physical condition to participate fully in clinical experiences required by the program of study. I have noted any limitations below.

Limitations (if any): ____

Provider Signature: _________________________ **Date:** ____/____/____ **Phone:** _____________

Provider Name (printed): ________________________ **Address:** ___________________________

Provider Type: ☐ MD ☐ DO ☐ APRN ☐ PA

Name: ____________ DOB: _________ PeopleSoft #: _________ Program: ______________

PART 2 – Immunization History & Titers

To be completed and signed by healthcare provider if used for submission of immunizations.

Measles, Mumps & Rubella (MMR) – You must demonstrate immunity to Measles, Mumps, and Rubella via positive IgG titers. If one or more of your primary titers is negative or equivocal, you will have to have a booster immunization and a repeat titer (your provider may recommend two boosters). You must submit titer labwork including quantitative results and reference ranges.

MMR Primary IgG Titers					
Measles	Titer Date:	____/____/____	Result:	☐ Positive ☐ Negative/Equivocal	☐ Titer Labwork attached
Mumps	Titer Date:	____/____/____	Result:	☐ Positive ☐ Negative/Equivocal	☐ Titer Labwork attached
Rubella	Titer Date:	____/____/____	Result:	☐ Positive ☐ Negative/Equivocal	☐ Titer Labwork attached

MMR Repeat Immunization *(required only if primary titer is negative/equivocal)*			
Repeat Dose #1 Date:	____/____/____	Repeat Dose #2 Date: *(if recommended by provider)*	____/____/____

MMR Repeat IgG Titers *(required only if primary titer is negative/equivocal)*					
Measles	Titer Date:	____/____/____	Result:	☐ Positive ☐ Negative/Equivocal	☐ Titer Labwork attached
Mumps	Titer Date:	____/____/____	Result:	☐ Positive ☐ Negative/Equivocal	☐ Titer Labwork attached
Rubella	Titer Date:	____/____/____	Result:	☐ Positive ☐ Negative/Equivocal	☐ Titer Labwork attached

Varicella – You must demonstrate immunity to Varicella via a positive IgG titer. If your primary titer is negative or equivocal, you will have to have a booster immunization and a repeat titer (your provider may recommend two boosters). You must submit titer labwork including quantitative results and reference ranges.

Varicella Primary IgG Titer				
Titer Date:	____/____/____	Result:	☐ Positive ☐ Negative/Equivocal	☐ Titer Lab work Attached

Varicella Repeat Immunization *(required only if primary titer is negative/equivocal)*			
Repeat Dose #1 Date:	____/____/___	Repeat Dose #2 Date: *(if recommended by provider)*	____/____/___

Varicella Repeat IgG Titer *(required only if primary titer is negative/equivocal)*				
Repeat Titer Date:	____/____/____	Result:	☐ Positive ☐ Negative/Equivocal	☐ Titer Lab work Attached

*****IF SUBMITTING THIS PAGE TO ADB/COMPLIO, PLEASE ALSO ATTACH PAGE 3 WITH PROVIDER SIGNATURE/DETAILS. YOUR SUBMISSION WILL BE REJECTED WITHOUT PROVIDER INFORMATION.*****

Name: ____________ DOB: __________ PeopleSoft #: __________ Program: ________________

PART 2 – Immunization History & Titers continued

Hepatitis B – You must demonstrate immunity to Hepatitis B via a positive quantitative surface antibody titer (HBsAb). If your primary titer is negative or equivocal, you will have to repeat the immunization series and have a repeat titer. You must submit titer labwork including quantitative results and reference ranges.

Hepatitis B Primary (HBsAb) Titer				
Titer Date:	____/____/____	Result:	☐ Positive ☐ Negative/Equivocal	☐ Titer Lab work Attached

Hepatitis B Repeat Immunization Series *(required only if primary titer is negative/equivocal)*					
Select One: ☐ 3-Shot Traditional Series ☐ 2-Shot Heplisav Series					
Repeat Dose #1 Date:	____/____/___	Repeat Dose #2 Date:	____/____/___	Repeat Dose #3 Date:	____/____/___

Hepatitis B Repeat HBsAb Titer *(required only if primary titer is negative/equivocal)*				
Repeat Titer Date:	____/____/____	Result:	☐ Positive ☐ Negative/Equivocal	☐ Titer Lab work Attached

Polio – Required ONLY for Nursing programs. You must submit A) proof of three OPV/IPV vaccines and a childhood OPV/IPV booster administered before age 8, B) proof of one OPV/IPV Adult Booster, or C) a positive Polio titer.

Previous Polio Vaccination			
OPV/IPV Dose #1 Date:	____/____/____	OPV/IPV Dose #2 Date:	____/____/____
OPV/IPV Dose #3 Date:	____/____/____	OPV/IPV Childhood Booster Date:	____/____/____

Alternate Polio Documentation (only one option required)				
OPV/IPV Adult Booster Date:	____/____/____			
Polio Titer Date:	____/____/____	Result:	☐ Positive ☐ Negative/Equivocal	☐ Titer Labwork attached

Tetanus – You must show proof of a current Tdap (Tetanus, Diphtheria, and Acellular Pertussis) immunization (administered within 10 years). *Programs in Allied Health Sciences, Kinesiology, Pharmacy, Physiology & Neurobiology, and Speech, Language, Hearing Sciences may allow a Td (Tetanus & Diphtheria) immunization under certain circumstances.*

Current Tetanus Booster		
☐ Tdap ☐ Td	Date:	___/___/___

Healthcare Provider Attestation

The information presented on this Immunization History & Titers form is true and accurate to the best of my knowledge.

Provider Signature: ______________________ **Date:** ____/____/____ **Phone:** ____________

Provider Name (printed): ______________________ **Address:** ________________________

Provider Type: ☐ MD ☐ DO ☐ APRN ☐ PA

Name: ________ DOB: ________ PeopleSoft #: ________ Program: ________

PART 3 – Annual Tuberculosis Requirement

Healthcare provider completes appropriate section. Students must satisfy annual Tuberculosis requirements using one of the methods listed below. **Note that the blood test option is preferred.**

If student has no history of TB and no history of positive TB screening, select one option:

- ☐ **Option A (Preferred)** – TB Blood Test (either QuantiFERON Gold or T-Spot)
- ☐ **Option B** – Two-Step Mantoux PPD Skin Test (four visits/two full tests performed 7-21 days apart)
- ☐ **Option C** – Single Baseline Mantoux PPD Skin Test (two visits) – *not acceptable for Allied Health Sciences, Nursing, Doctor of Physical Therapy, Athletic Training, or Psychological Sciences programs*

If student does have a history of TB or history of positive TB screening, Option D is also required:

1. Student completes Annual TB Screening Questionnaire with provider attestation (page 5 of this packet)
2. Submit most recent Chest X-Ray Results

Option A (Preferred): Blood Test

Date: ____/____/____	☐ QuantiFERON Gold	☐ T-Spot	☐ Labwork Attached
Result:	☐ Positive *(requires completion of option D)* ☐ Negative	Signature:________	

Option B: Two-Step Mantoux Skin Test PPD

PPD Step #1			
Date Administered:	____/____/____	Signature:	________
Date Read:	____/____/____		
Result in mm induration:________		Signature:	________
Step #1 PPD Result:	☐ Negative	☐ Positive *(requires completion of option D)*	
PPD Step #2 (7-21 days after PPD Step #1)			
Date Administered:	____/____/____	Signature:	________
Date Read:	____/____/____		
Result in mm induration:________		Signature:	________
Step #2 PPD Result:	☐ Negative	☐ Positive *(requires completion of option D)*	

Option C: Single Baseline Mantoux Skin Test PPD – *not accepted for Allied Health Sciences, Nursing, Doctor of Physical Therapy, Athletic Training, or Psychological Sciences*

Date Administered:	____/____/____	Signature:	________
Date Read:	____/____/____		
Result in mm induration: ________		Signature:	________
PPD Result:	☐ Negative	☐ Positive *(requires completion of option D)*	

Option D: Screening Questionnaire, Chest X-Ray & Treatment Documentation

☐ Annual TB Screening Questionnaire attached (page 5)	Date of Last X-Ray: ____/____/____
Treatment Completed? ☐ Yes (attach documentation) ☐ No	X-Ray Results: ☐ Normal ☐ Abnormal

Healthcare Provider Attestation

The information presented on this Annual Tuberculosis form is true and accurate to the best of my knowledge.

Provider Signature: ________ **Date:** ____/____/____ **Phone:** ________

Provider Name (printed): ________ **Address:** ________

Provider Type: ☐ MD ☐ DO ☐ APRN ☐ PA

Name: ______________ **DOB:** __________ **PeopleSoft #:** __________ **Program:** __________________

PART 3 – Annual Tuberculosis Requirement continued

Annual Tuberculosis (TB) Screening Questionnaire

To be completed by student and provider only if student has history of TB or history of positive TB test or if any current test (blood test or PPD) is positive. In addition to this questionnaire, student must submit most recent chest x-ray (dated within five years).

Have you experienced any of the following symptoms in the past year? Please indicate yes or no for each item.

1. Persistent productive cough? ☐ Yes ☐ No
2. Coughing up blood? ☐ Yes ☐ No
3. Chest pain? ☐ Yes ☐ No
4. Shortness of breath / difficulty breathing? ☐ Yes ☐ No
5. Unexplained fever lasting more than 3 days? ☐ Yes ☐ No
6. Unexplained night sweats? ☐ Yes ☐ No
7. Unexplained sudden weight loss? ☐ Yes ☐ No
8. Unexplained fatigue / run down feeling? ☐ Yes ☐ No
9. Unexplained swollen lymph nodes or masses in your armpit or neck area? ☐ Yes ☐ No

Student Attestation

The information presented on this Annual Tuberculosis Screening Questionnaire is true and accurate to the best of my knowledge.

Student Signature: ________________________ **Date:** ____/____/____

Student Name (printed): ____

Healthcare Provider Attestation

I certify that this student has completed all recommended treatment for a history of TB infection or a history of positive TB test(s).

Provider Signature: ________________________ **Date:** ____/____/____ **Phone:** ____________

Provider Name (printed): _______________________ **Address:** __________________________

Provider Type: ☐ MD ☐ DO ☐ APRN ☐ PA