UCONN
UNIVERSITY OF CONNECTICUT

2017 Clinical Rotation Health Review

Part 1: To be completed by Student

LAST NAME	FIRST NAME	MI	Date of Birth

PeopleSoft ID #	Email	Cell or Local Phone

Program

☐ Athletic Training ☐ Allied Health Sciences ☐ Nursing ☐ Physical Therapy ☐ Pharmacy ☐ 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:

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Clinical Rotation Health Review Form

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.

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

A copy of the lab results must accompany this form.

Last Name	First Name	MI	PeopleSoft ID #

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

***A Hepatitis B Titer is required only if the Hepatitis B series has been completed within the past 2 years, unless checked above.*

***NOTE: Negative immunity response to the disease states listed above may require boosters, immunization and/or blood tests. YOU are responsible for scheduling follow-ups to complete the series.**

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

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

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:** _____

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

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Clinical Rotation Health Review Form

Part 3: Physical Examination to be completed by Healthcare Provider

Last Name	First Name	MI	PeopleSoft ID #

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

WNL	*Check Box for 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

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:** _____