University of Connecticut 2017-2018 Student Health History – Form A

UConn Student Health Services, 234 Glenbrook Rd, Storrs, CT 06269 Phone: 860-486-4700 SHS.UCONN.EDU

THIS FORM MUST BE SUBMITTED BY JULY 1 FOR FALL SEMESTER AND JANUARY 1 FOR SPRING SEMESTER

Student Last Name	Student First Name	Student Middle Name

Date of Birth: MM/DD/YYYY	Legal Gender:	Preferred Gender Identity:	Net ID

YEAR BEGINNING AT UCONN _____ ☐ Fall ☐ Spring **CAMPUS ATTENDING**: ☐ STORRS ☐ AVERY POINT ☐ HARTFORD ☐ STAMFORD ☐ WATERBURY

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:
X		X	

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

IMMUNIZATION HISTORY

Except for questions 4a-4d, all information on Form A must be documented by a healthcare provider.

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	**Dose #1** MM / DD / YYYY	**Dose #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.			
OR Measles Single Vaccination	Dose #1 MM / DD / YYYY	Dose #2 MM / DD / YYYY	**OR**	**Measles Titer** MM / DD / YYYY	**Result** ☐ Immune ☐ Not immune	**OR** **Measles Disease** MM / DD / YYYY
AND Mumps Single Vaccination	Dose #1 MM / DD / YYYY	Dose #2 MM / DD / YYYY	**OR**	**Mumps Titer** MM / DD / YYYY	**Result** ☐ Immune ☐ Not immune	**OR** **Mumps Disease** MM / DD / YYYY
AND Rubella Single Vaccination	Dose #1 MM / DD / YYYY	Dose #2 MM / DD / YYYY	**OR**	**Rubella Titer** MM / DD / YYYY	**Result** ☐ Immune ☐ Not immune	**OR** **Rubella Disease** MM / DD / YYYY

2. REQUIRED OF ALL STUDENTS BORN AFTER 1979

VARICELLA VACCINATION	**Dose #1** MM / DD / YYYY	**Dose #2** MM / DD / YYYY	**OR**	**Varicella Titer** MM / DD / YYYY	**Result** ☐ Immune ☐ Not immune	**OR** **Chicken Pox Disease** MM / DD / YYYY

3. REQUIRED OF ALL STUDENTS LIVING IN UNIVERSITY HOUSING

MENINGITIS VACCINATION (MCV4) Must cover strains A, C, Y, W-135 (Menactra, Menveo, 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 **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. A chest x-ray is unacceptable for 4b – 4d YES answers.

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.

TB BLOOD TEST (IGRA)	OR	TB SKIN TEST (PPD)	CHEST X-RAY	MEDICATION TREATMENT
Recommended if prior BCG ☐ Quantiferon ☐ T-Spot **Date:**_____ **Result:** ☐ NEG ☐ POS		**Date Planted:** _____ **Date Read:** _____ **Interpretation:** ☐ NEG ☐ POS mm of induration: _____	• Only accepted/required if past or current positive TB skin or blood test. • Not required if completed treatment for TB **Chest X-ray Date:**_____ ☐ Normal ☐ Abnormal	☐ Latent TB Infection ☐ Active TB Infection **Date(s):**_____ List Medication(s):

Submit all completed forms and any attachments by scanning and uploading to the Student Health Portal

myHealth.uconn.edu

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5. STRONGLY RECOMMENDED VACCINATIONS

TETANUS, DIPHTHERIA, PERTUSSIS (within the last 10 years)	☐ Tdap ☐ Td	Date: MM / DD / YYYY			
MENINGOCOCCAL SEROGROUP B	☐ Trumenba (MenB-FHbp) ☐ Bexsero (MenB-4C)	Dose #1: MM / DD / YYYY	Dose #2: MM / DD / YYYY	Dose #3 (if Trumenba): MM / DD / YYYY	
HEPATITIS B VACCINATION SERIES	Dose #1: MM / DD / YYYY	Dose #2: MM / DD / YYYY	Dose #3: MM / DD / YYYY	Hep B Surface Antibody Titer MM / DD / YYYY	Result ☐ Immune ☐ Not Immune
HUMAN PAPILLOMAVIRUS	☐ HPV4 ☐ HPV9	Dose #1: MM / DD / YYYY	Dose #2: MM / DD / YYYY	Dose #3: MM / DD / YYYY	

6. 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.

X_____
Provider initial

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.

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

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#:

Questions? Go to shs.uconn.edu/immunization-FAQ

List of High Risk Tuberculosis Countries for TB Questionnaire on page 1 of Student Health History Form A

Afghanistan	Colombia	Kazakhstan	New Caledonia	South Africa
Algeria	Comoros	Kenya	Nicaragua	Sri Lanka
Angola	Congo	Kiribati	Niger	Sudan
Anguilla	Côte d'Ivoire	Kuwait	Nigeria	Suriname
Argentina	Democratic People's	Kyrgyzstan	Northern Mariana	Swaziland
Armenia	Republic of Korea	Lao PDR	Islands	Syrian Arab
Azerbaijan	Democratic Republic	Latvia	Pakistan	Republic
Bangladesh	of the Congo	Lesotho	Palau	Taiwan
Belarus	Djibouti	Liberia	Panama	Tajikistan
Belize	Dominican Republic	Libyan Arab	Papua New Guinea	Thailand
Benin	Ecuador	Jamahiriya	Paraguay	Timor-Leste
Bhutan	El Salvador	Lithuania	Peru	Togo
Bolivia	Equatorial Guinea	Madagascar	Philippines	Tonga
Bosnia and	Eritrea	Malawi	Portugal	Tunisia
Herzegovina	Ethiopia	Malaysia	Qatar	Turkmenistan
Botswana	Gabon	Maldives	Republic of Korea	Tuvalu
Brazil	Gambia	Mali	Republic of	Uganda
Brunei Darussalam	Georgia	Marshall Islands	Macedonia	Ukraine
Bulgaria	Ghana	Mauritania	Republic of Moldova	United Republic of
Burkina Faso	Greenland	Mauritius	Romania	Tanzania
Burundi	Guam	Mexico	Russian Federation	Uruguay
Cambodia	Guatemala	Micronesia	Rwanda	Uzbekistan
Cameroon	Guinea	Mongolia	Sao Tome and	Vanuatu
Cape Verde	Guinea-Bissau	Montenegro	Principe	Venezuela
Central African	Guyana	Morocco	Senegal	Viet Nam
Republic	Haiti	Mozambique	Serbia	Yemen
Chad	Honduras	Myanmar	Sierra Leone	Zambia
China	India	Namibia	Singapore	Zimbabwe
China, Hong Kong	Indonesia	Nauru	Solomon Islands	
China, Macao	Iraq	Nepal	Somalia	

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University of Connecticut 2017-2018 Student Health History – Form B

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Student Last Name	Student First Name	Student Middle Name

Date of Birth: MM/DD/YYYY	Legal Gender:	Preferred Gender Identity:	Net ID

Permanent Home Information

Student's Preferred E-mail Address

Student's Cell Phone | Home Phone

Home Address

Notify in Case of Emergency

Name | Relationship

Home Phone | Cell/Work Phone

Address

X _____
Student Initial

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

PHONE # | FAX #

Address

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

Medication Allergy:	Reaction:	Food Allergy:	Reaction:
☐ Insect (Bee/Wasp stings)	Reaction:	X-ray Contrast ☐	Reaction:
Are any of these life threatening? ☐ **Yes** ☐ **No** List if yes.		**Do you carry an Epi Pen?** ☐ **Yes** ☐ **No** List reason if yes.	

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 any of the items that you have circled above or if there are any 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: _____

Storrs students who wish to discuss coordination of care issues for ongoing health 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.

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