

## 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](mailto: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](http://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.

## 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).

<b>To Do</b>	<input type="checkbox"/> 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. <input type="checkbox"/> Review sections and make sure you understand what is required for your program: <ul style="list-style-type: none"> <li><input type="checkbox"/> Vital Signs (required for all programs unless exam is conducted via telehealth)</li> <li><input type="checkbox"/> Normal/Abnormal for Each Area (required for all programs)</li> <li><input type="checkbox"/> Color Vision Screening (required for all Allied Health Sciences and Nursing programs)</li> <li><input type="checkbox"/> N95 Fit Test Clearance (required for all programs; Note: Fit test not required, just clearance)</li> </ul>
<b>To Submit</b>	<input type="checkbox"/> Completed and signed page 4 of this packet <input type="checkbox"/> Please make sure all sections are completed except if marked “optional” or not required for program
<b>Follow Up Steps</b>	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 5-6)

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

<b>To Do</b>	<input type="checkbox"/> Schedule appointment for your Primary Measles, Mumps, and Rubella IgG titers
<b>To Submit</b>	<input type="checkbox"/> [Optional] Completed pages 5-6 of this packet showing MMR titer results and any boosters <input type="checkbox"/> Titer labwork showing quantitative titer results and reference ranges
<b>Follow Up Steps</b>	<p>If one or more of your primary titers is negative or equivocal:</p> <ol style="list-style-type: none"> <li>1. Begin repeat immunization series with MMR booster &amp; submit booster document to Complio</li> <li>2. Your provider may recommend two boosters; follow guidance and submit documents</li> <li>3. Schedule needed repeat MMR IgG titer(s) on appropriate schedule and submit labwork</li> </ol> <p>If you've completed steps 1-3 above and any repeat titer is negative or equivocal:</p> <ol style="list-style-type: none"> <li>1. Have your doctor complete a non-responder form and submit in Complio</li> <li>2. Contact your clinical/field placement director/coordinator to receive guidance about next steps.</li> </ol>

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

<b>To Do</b>	<input type="checkbox"/> Schedule appointment for your Primary Varicella IgG titer
<b>To Submit</b>	<input type="checkbox"/> [Optional] Completed pages 5-6 of this packet showing Varicella titer result & any boosters <input type="checkbox"/> Titer labwork showing quantitative titer result and reference ranges
<b>Follow Up Steps</b>	<p>If your primary titer is negative or equivocal:</p> <ol style="list-style-type: none"> <li>1. Begin repeat immunization series with Varicella booster &amp; submit booster document to Complio</li> <li>2. Your provider may recommend two boosters; follow guidance and submit documents as you go</li> <li>3. Schedule repeat Varicella IgG titer on appropriate schedule and submit labwork</li> </ol> <p>If you've completed steps 1-3 above and your repeat titer is negative or equivocal:</p> <ol style="list-style-type: none"> <li>1. Have your doctor complete a non-responder form and submit in Complio</li> <li>2. Contact your clinical/field placement director/coordinator to receive guidance about next steps.</li> </ol>

**PART 2 – Immunization History & Titers continued (pages 5-6)**

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

<b>To Do</b>	<input type="checkbox"/> Schedule appointment for your Primary Hepatitis B titer (HBsAb)
<b>To Submit</b>	<input type="checkbox"/> [Optional] Completed pages 4-5 of this packet showing Hep B titer result & any boosters <input type="checkbox"/> Titer labwork showing quantitative titer result and reference ranges
<b>Follow Up Steps</b>	<p>If your primary titer is negative or equivocal:</p> <ol style="list-style-type: none"> <li>1. Begin repeat immunization series with Hep B Booster 1 &amp; submit booster document to Complio</li> <li>2. Continue with Hep B Boosters 2 &amp; 3 on appropriate schedule, submitting documents as you go</li> <li>3. Schedule repeat Hep B (HBsAb) titer on appropriate schedule and submit labwork</li> </ol> <p>If you've completed steps 1-3 above and your repeat titer is negative or equivocal:</p> <ol style="list-style-type: none"> <li>1. Have your doctor complete a non-responder form and submit in Complio</li> <li>2. Contact your clinical/field placement director/coordinator to receive guidance about next steps.</li> </ol>

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

<b>To Do</b>	<input type="checkbox"/> Gather previous Polio vaccination records or have provider complete page 6
<b>To Submit</b>	<input type="checkbox"/> Completed pages 5-6 of this packet or other immunization history document/record. <input type="checkbox"/> 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.

<b>To Do</b>	<input type="checkbox"/> Gather previous tetanus vaccination records or have provider complete page 6
<b>To Submit</b>	<input type="checkbox"/> Completed pages 5-6 of this packet or other immunization history document/record.
<b>Follow Up Steps</b>	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 7-8)**

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

<b>To Do</b>	<input type="checkbox"/> Determine whether you have prior history of TB or history of a positive TB screening test. <ul style="list-style-type: none"> <li><input type="checkbox"/> If you have <b>no prior history of TB</b> or positive TB screening, <b>select and complete one of these options</b> in consultation with your healthcare provider and/or program: <ul style="list-style-type: none"> <li><input type="checkbox"/> Option A (Preferred) – Blood Test (QuantiFERON Gold or T-Spot)</li> <li><input type="checkbox"/> Option B – 2-Step Mantoux PPD Skin Test (two PPD tests [plant and read], 7-21 days apart)</li> <li><input type="checkbox"/> Option C – Baseline Single-Step Mantoux PPD Skin Test (<i>not acceptable for Allied Health Sciences, Nursing, or Psychological Sciences programs</i>)</li> </ul> </li> <li><input type="checkbox"/> If you have <b>prior history of TB</b> and/or positive TB screening, follow these steps: <ol style="list-style-type: none"> <li>1. Complete the Annual TB Symptom Screening Questionnaire on page 8</li> <li>2. Gather your most recent chest x-ray results</li> <li>3. Obtain documentation from your healthcare provider that you have completed treatment</li> </ol> </li> </ul>
<b>To Submit</b>	<input type="checkbox"/> Completed and signed page 7 of this packet or other lab report/documentation of selected test option <input type="checkbox"/> If applicable, questionnaire on page 8 of this packet <input type="checkbox"/> 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. 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

**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:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative/Equivocal <input type="checkbox"/> Titer Labwork attached
Mumps	Titer Date: ___/___/___	Result:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative/Equivocal <input type="checkbox"/> Titer Labwork attached
Rubella	Titer Date: ___/___/___	Result:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative/Equivocal <input type="checkbox"/> Titer Labwork attached

MMR Repeat Immunization <i>(required only if primary titer is negative/equivocal)</i>	
Repeat Dose #1 Date: ___/___/___	Repeat Dose #2 Date: ___/___/___ <i>(if recommended by provider)</i>

MMR Repeat IgG Titers <i>(required only if primary titer is negative/equivocal)</i>			
Measles	Titer Date: ___/___/___	Result:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative/Equivocal <input type="checkbox"/> Titer Labwork attached
Mumps	Titer Date: ___/___/___	Result:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative/Equivocal <input type="checkbox"/> Titer Labwork attached
Rubella	Titer Date: ___/___/___	Result:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative/Equivocal <input type="checkbox"/> 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:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative/Equivocal <input type="checkbox"/> Titer Lab work Attached

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

Varicella Repeat IgG Titer <i>(required only if primary titer is negative/equivocal)</i>		
Repeat Titer Date: ___/___/___	Result:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative/Equivocal <input type="checkbox"/> Titer Lab work Attached

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:	<input type="checkbox"/> Positive	<input type="checkbox"/> Titer Lab work Attached
		<input type="checkbox"/> Negative/Equivocal	

Hepatitis B Repeat Immunization Series <i>(required only if primary titer is negative/equivocal)</i>			
Select One: <input type="checkbox"/> 3-Shot Traditional Series <input type="checkbox"/> 2-Shot Heplisav Series			
Repeat Dose #1 Date: _____/_____/_____	Repeat Dose #2 Date: _____/_____/_____	Repeat Dose #3 Date: _____/_____/_____	

Hepatitis B Repeat HBsAb Titer <i>(required only if primary titer is negative/equivocal)</i>			
Repeat Titer Date: _____/_____/_____	Result:	<input type="checkbox"/> Positive	<input type="checkbox"/> Titer Lab work Attached
		<input type="checkbox"/> Negative/Equivocal	

**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 <i>(only one option required)</i>			
OPV/IPV Adult Booster Date: _____/_____/_____			
Polio Titer Date: _____/_____/_____	Result:	<input type="checkbox"/> Positive	<input type="checkbox"/> Titer Labwork attached
		<input type="checkbox"/> Negative/Equivocal	

**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	
<input type="checkbox"/> Tdap <input type="checkbox"/> 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

**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 programs in Allied Health Sciences, Nursing or Psychological Sciences*

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

1. Student completes Annual TB Screening Questionnaire (page 8 of this packet)
2. Submit most recent Chest X-Ray Results
3. Submit additional signed documentation that treatment was completed

**Option A (Preferred): Blood Test**

Date: ____/____/____	<input type="checkbox"/> QuantiFERON Gold	<input type="checkbox"/> T-Spot	<input type="checkbox"/> Labwork Attached
Result:	<input type="checkbox"/> Positive ( <i>requires completion of option D</i> )	Signature: _____	
	<input type="checkbox"/> Negative		

**Option B: Two-Step Mantoux Skin Test PPD**

PPD Step #1	
Date Administered: ____/____/____	Signature: _____
Date Read: ____/____/____	
Result in mm induration: _____	Signature: _____
<b>Step #1 PPD Result:</b> <input type="checkbox"/> Negative <input type="checkbox"/> Positive ( <i>requires completion of option D</i> )	
PPD Step #2 (7-21 days after PPD Step #1)	
Date Administered: ____/____/____	Signature: _____
Date Read: ____/____/____	
Result in mm induration: _____	Signature: _____
<b>Step #2 PPD Result:</b> <input type="checkbox"/> Negative <input type="checkbox"/> Positive ( <i>requires completion of option D</i> )	

**Option C: Single Baseline Mantoux Skin Test PPD – only acceptable for**

Date Administered: ____/____/____	Signature: _____
Date Read: ____/____/____	
Result in mm induration: _____	Signature: _____
<b>PPD Result:</b> <input type="checkbox"/> Negative <input type="checkbox"/> Positive ( <i>requires completion of option D</i> )	

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

<input type="checkbox"/> Annual TB Screening Questionnaire attached (page 8)	Date of Last X-Ray: ____/____/____
Treatment Completed? <input type="checkbox"/> Yes (attach documentation) <input type="checkbox"/> No	X-Ray Results: <input type="checkbox"/> Normal <input type="checkbox"/> 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

**PART 3 – Annual Tuberculosis Requirement continued**

**Annual Tuberculosis (TB) Screening Questionnaire**

To be completed by student 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 and documentation of completion of treatment.

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

- |                                                                           |                              |                             |
|---------------------------------------------------------------------------|------------------------------|-----------------------------|
| 1. Persistent productive cough?                                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Coughing up blood?                                                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Chest pain?                                                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Shortness of breath / difficulty breathing?                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Unexplained fever lasting more than 3 days?                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Unexplained night sweats?                                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Unexplained sudden weight loss?                                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Unexplained fatigue / run down feeling?                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Unexplained swollen lymph nodes or masses in your armpit or neck area? | <input type="checkbox"/> Yes | <input type="checkbox"/> 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):** \_\_\_\_\_