# Clinical Rotation Health Review Form

## Part 1: To be completed by Student

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>MI</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>PeopleSoft ID #</td>
<td>Email</td>
<td>Cell or Local Phone</td>
<td>@uconn.edu</td>
</tr>
</tbody>
</table>

**Program**
- [ ] Allied Health Sciences
- [ ] Athletic Training
- [x] Nursing
- [ ] Pharmacy
- [ ] Physical Therapy
- [ ] Psych/Clinical Psychology
- [ ] Social Work
- [ ] Speech & Hearing

**CAMPUS**
- [ ] Avery Point
- [ ] Hartford
- [ ] Stamford
- [ ] Storrs
- [ ] Waterbury

**Permanent Home Information:**
- Home Phone
- Street Address
- City State Zip

**Notify in Case of Emergency:**
- Name / Relationship
- Home Phone Cell/Work Phone
- Street Address
- City State Zip

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Any questions concerning your requirements and submission deadlines should be directed to your Program Contact listed here:

### Allied Health Sciences (including Dietetics, Medical Laboratory Sciences & Diagnostic Genetic Sciences)
- **Bambi Mroz**
  - Business Services Supervisor
  - 358 Mansfield Rd, Unit 1101
  - Storrs, CT 06269-1101
  - Phone: 860-486-0013
  - Fax: 860-486-5375
  - bambi.mroz@uconn.edu

### Nursing
- **Amelia Hinchliffe**
  - Contracts & Compliance
  - 231 Glenbrook Road, Unit 4026
  - Storrs, CT 06269-4026
  - Phone: 860-486-4104
  - Fax: 860-486-7975
  - amelia.hinchliffe@uconn.edu

### Physical Therapy & Athletic Training
- **Rachel C. Chassé-Terebo**
  - Immunization & Clinical Compliance Coordinator
  - 3107 Horsebarn Hill Road, Unit 1101
  - Storrs, CT 06269-1101
  - Phone: 860-486-1854
  - Fax: 860-486-1588
  - rachel.chasse@uconn.edu

### Pharmacy
- **Joshlyn Lucas-Nash**
  - Program Assistant
  - 69 North Eagleville Road Unit 3092
  - Storrs, CT 06268
  - Phone: 860-486-5848
  - Fax: 860-486-9095
  - joshlyn.lucas-nash@uconn.edu

### Psychology/Clinical Psychology
- **Debbie Vardon**
  - Administrative Manager, Clinical Training Program
  - 406 Babbidge Road Unit 1020
  - Storrs, CT 06269-1020
  - Phone: 860-486-2057
  - Fax: 860-486-2760
  - debra.vardon@uconn.edu

### Social Work
- **Cheryl Jackson-Morris, MSW**
  - Associate Director for Field Education
  - 38 Prospect Street
  - Hartford, CT 06103
  - Phone: 959-200-3609
  - Fax: 860-244-2240
  - cheryl.jackson-morris@uconn.edu

### Speech, Language, and Hearing Sciences
- **Sirrah Galligan**
  - Academic Program Coordinator
  - 850 Bolton Road, Unit 1085
  - Storrs, CT 06269
  - Phone: 860-486-2817
  - Fax: 860-486-4948
  - slhs@uconn.edu

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CONTINUE TO PART 2 FOR IMMUNIZATION HISTORY ►►►
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.

→ IgG Titers for ☒ Measles, ☐ Mumps, ☒ Rubella, ☐ Varicella, ☐ Hepatitis B, ☐ Polio (check all that are required)

A copy of the lab results must accompany this form. Tests done at UConn SHS can be obtained by going to http://shs.uconn.edu/request-personal-health-info/

Last Name                                      First Name                                      MI                                      PeopleSoft ID #

<table>
<thead>
<tr>
<th>DISEASE</th>
<th>PEDIATRIC VACCINATION 1 DATE</th>
<th>PEDIATRIC VACCINATION 2 DATE</th>
<th>IgG TITER DATE</th>
<th>TITER RESULTS (Immune = Positive)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEASLES</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>☒ IMMUNE ☐ NON- IMMUNE*</td>
</tr>
<tr>
<td>MUMPS</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>☒ IMMUNE ☐ NON- IMMUNE*</td>
</tr>
<tr>
<td>RUBELLA</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>☒ IMMUNE ☐ NON- IMMUNE*</td>
</tr>
<tr>
<td>VARICELLA</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>☒ IMMUNE ☐ NON- IMMUNE*</td>
</tr>
<tr>
<td>POLIO</td>
<td>1st O/ IPV DATE /</td>
<td>2nd O/ IPV DATE /</td>
<td>BOOSTER DATE</td>
<td>☐ IMMUNE ☐ NON- IMMUNE*</td>
</tr>
<tr>
<td>HEPATITIS B**</td>
<td>1st HEP B DATE /</td>
<td>2nd HEP B DATE /</td>
<td>3rd HEP B DATE</td>
<td>☐ IMMUNE ☐ NON- IMMUNE*</td>
</tr>
</tbody>
</table>

*NOTE: Negative immune response to the diseases listed above may require boosters, repeat immunization(s) and/or or repeat blood tests. STUDENTS are responsible for scheduling follow-ups to satisfy the clinical requirement. Supplemental or repeat vaccination(s)/titer(s) documentation should be provided separately.

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 2-step tuberculosis skin test (TST)/ PPD (below).

IGRA/BAMT Blood test, either:
☐ Quantiferon ☐ T-Spot

IGRA/BAMT Date: / /

Result: ☐ Negative ☐ Positive ☐ Indeterminate

2nd TST/PPD (a 2-Step PPD is required)

DATE PLANTED: / / DATE READ: / / mm ______ RESULTS: ☐ 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):

TREATMENT 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: ____________________________
**Part 3: Physical Examination to be completed by Healthcare Provider.** *(Please fill out form completely.)*

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>PeopleSoft ID #</th>
</tr>
</thead>
</table>

**Vital Signs**

<table>
<thead>
<tr>
<th>BP:</th>
<th>Pulse:</th>
<th>Height:</th>
<th>Weight:</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>VNL</th>
<th>Check Box for findings within normal limits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Head/ears/nose/throat</td>
</tr>
<tr>
<td></td>
<td>Mouth/teeth</td>
</tr>
<tr>
<td></td>
<td>Eyes/ophthalmoscopic/color vision deficiency screening</td>
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<tr>
<td></td>
<td>Spine/neck</td>
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<tr>
<td></td>
<td>Nodes</td>
</tr>
<tr>
<td></td>
<td>Chest/lungs</td>
</tr>
<tr>
<td></td>
<td>Heart</td>
</tr>
<tr>
<td></td>
<td>Abdomen</td>
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<tr>
<td></td>
<td>Breast/Testicles</td>
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<tr>
<td></td>
<td>Extremities</td>
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<tr>
<td></td>
<td>Skin</td>
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<tr>
<td></td>
<td>Neurologic</td>
</tr>
<tr>
<td></td>
<td>Psychological</td>
</tr>
</tbody>
</table>

**Impression (Required)**

**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:** _______________________________________________________

*Rev 12/15/2017*