UCONN HEALTH

Employee Health
Occupational Medicine

(Patient Identification Label)
Name:
Medical Record/DOB:

Verification of Health Requirements

[To be completed by a licensed MD, DO, or duly authorized Advanced Practice Practitioner]

Student's Full Name: _____ DOB: _____

PLEASE INITIAL EACH OF THE FOLLOWING STATEMENTS IF MET BY THE STUDENT.

___ **Physical Exam**: Completion of a physical exam within the past 12 months.
Date of physical exam: ____/____/____

___ **Measles/Mumps**: Meets at least one (1) option below.
Option A: Completed two doses of live measles and mumps vaccines (MMR) administered at least 28 days apart (one vaccine must be documented after 1980)
Option B: Positive IgG titer for measles and mumps
Option C: Birth before January 1, 1957

___ **Rubella**: Meets at least one (1) option below.
Option A: Completed one dose of live rubella vaccine (at least one MMR)
Option B: Positive IgG titer for rubella

___ **Varicella**: Meets at least one (1) option below.
Option A: Completed two doses of varicella vaccine
Option B: Positive IgG titer for varicella

___ **Hep B**: Hepatitis B immunity based upon a positive Hepatitis B Surface antibody (HBsAb) titer.

___ **Tetanus**: Meets at least one (1) option below.
Option A: Completed TDaP
Option B: TD vaccine within the last 10 years

___ **TB**: Meets at least one (1) option below within the past 12 months.
Option A: Negative QuantiFERON gold test
Option B: Evidence of two non-reactive PPD's (two-step) *[First year student]*
Option C: Evidence of one non-reactive PPD *[Third year student]*
Option D: Documentation of treatment and resolution of active TB
Option E: Documentation of an absence of symptoms and a negative chest x-ray after a positive PPD or positive QuantiFERON gold test
Date of result: ___/___/___ Additional Date for Option B: ___/___/___

___ **Flu**: Up to date influenza immunization, if applicable between October 1st and April 1st. If the patient has declined due to medical or religious exemption, please do NOT initial.

Covid-19: Vaccination is not required, however we highly recommend you be vaccinated against COVID-19 according to the most recent CDC guidance.

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Provider Attestation of Student Fitness for Participation in Clinical Field 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 UConn Health School of Medicine. Additionally, it is my opinion that the student is free of all communicable diseases. I have noted any limitations below.

Are there any restrictions/limitations? ☐No ☐Yes (if yes, please specify):

_____

_____

Provider Signature: _____ Date: ___/___/___

Provider Name (printed): _____

Provider Type: ☐MD ☐DO ☐APRN ☐PA

Address: _____ Phone: _____

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