

## Employee Health Occupational Medicine

(Patient Identification Label)

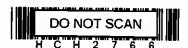
Name:

Medical Record/DOB:

## **Verification of Health Requirements**

[10 be completed by a licensed MD, DO, or duly author	ized 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 to Date of physical exam:///	within the past 12 months.
Measles/Mumps: Meets at least one (1) option be Option A: Completed two doses of live measle at least 28 days apart (one vaccine must be do Option B: Positive IgG titer for measles and me Option C: Birth before January 1, 1957	es and mumps vaccines (MMR) administered ocumented after 1980)
Rubella: Meets at least one (1) option below.  Option A: Completed one dose of live rubella volume option B: Positive IgG titer for rubella	vaccine (at least one MMR)
Varicella: Meets at least one (1) option below.  Option A: Completed two doses of varicella va Option B: Positive IgG titer for varicella	ccine
Hep B: Hepatitis B immunity based upon a positive	ve 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 Option A: Negative QuantiFERON gold test Option B: Evidence of two non-reactive PPD's Option C: Evidence of one non-reactive PPD (Option D: Documentation of treatment and resure Option E: Documentation of an absence of synpositive PPD or positive QuantiFERON gold te Date of result:/ Additional Date of	(two-step) [First year student] Third year student] olution of active TB nptoms and a negative chest x-ray after a st
Flu: Up to date influenza immunization, if applicate patient has declined due to medical or religious exemp	ole between October 1 <sup>st</sup> and April 1 <sup>st</sup> . If the otion, 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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Student's Full Name:	DOB:	
Provider Attestation of Student Fitness for Participati	ion 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 (i		
Provider Signature:	Date: / /	
Provider Name (printed):		
Provider Type: □MD □DO □APRN □PA		
Address:	Phone:	