UNIVERSITY OF CONNECTICUT STUDENT HEALTH HISTORY FORM

Submit all completed forms and any attachments by scanning and uploading to the Student Health Portal - myHealth.uconn.edu

Student Last Name:	Student First Name:	Student Middle Name:	Pronouns:

Date of Birth:	Sex Assigned at Birth:	Gender Identity:	Net ID:	Chosen Name:
MM/DD/YYYY				

IMMUNIZATION HISTORY

1. MEASLES, MUMPS, RUBELLA (MMR) Vaccination - required of all students born after 1957

OPTION 1:	Measles, Mumps, Rubella (MMR) Vaccination (First dose must be given on or after your first birthday to be accepted)	**Dose #1** MM / DD / YYYY	**Dose #2** MM / DD / YYYY
OPTION 2:	In lieu of proof of vaccination above, a titer showing immunity to each individual disease is an acceptable alternative to the vaccination.		
	Measles Titer Result: ☐ Immune ☐ Not immune Date _____ MM/DD/YYYY Mumps Titer Result: ☐ Immune ☐ Not immune Date _____ MM/DD/YYYY Rubella Titer Result: ☐ Immune ☐ Not immune Date _____ MM/DD/YYYY *If not immune, you are required to receive a booster MMR and repeat the titer or receive two MMR vaccines in lieu of the booster and titer		
OPTION 3:	An incidence of disease will take the place of a vaccine requirement. (Must be filled in by a physician/APRN/PA)		
	Measles Disease MM/DD/YYYY	Mumps Disease MM/DD/YYYY	Rubella Disease MM/DD/YYYY

2. VARICELLA Vaccination - required for all students born after 1979

OPTION 1:	Varicella Vaccination (First dose must be given on or after your first birthday to be accepted)	**Dose #1** MM / DD / YYYY	**Dose #2** MM / DD / YYYY
OPTION 2:	In lieu of proof of vaccination above, a titer showing immunity to the disease is an acceptable alternative to the vaccination.		
	Varicella Titer Result: ☐ Immune ☐ Not immune Date _____ MM/DD/YYYY *If not immune, you are required to receive a booster and repeat the titer or receive two Varicella vaccines in lieu of the booster and titer		
OPTION 3:	An incidence of disease will take the place of a vaccine requirement. (Must be filled in by a physician/APRN/PA)	Varicella Disease MM/DD/YYYY	

3. MENINGOCOCCAL(MCV4) Vaccination - Required of all students living in University housing Supporting documentation required

☐Menactra ☐ Menveo ☐Nimenrix ☐ MenQuadfi **Must cover strains A, C, Y, W-135** **Polysaccharide strain not accepted**	**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.

4. 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.

Date of last physical exam (MM/DD/YYYY): _____ / _____ / _____

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.

5. SICKLE CELL TRAIT TEST - Required of all NCAA Student Athletes ONLY

The University of Connecticut mandates that all NCAA Division I student-athletes provide proof of their Sickle Cell Trait Testing status prior to participating in any athletic activities at UConn. A copy of the lab report must be uploaded to your Student Health Portal.

6. Tuberculosis(TB) Risk Questionnaire required of all students: located on Student Health Portal at myhealth.uconn.edu

Signature of Health Care Practitioner (MD / DO / APRN / PA)

By signing below, I am certifying the accuracy of the information documented on the Student Health History Form.

Signature_____ Date_____ Phone_____

Name (print) : Address:

NPI#:

Consent for Treatment, Use and Disclosure of Health Information, & Financial Agreement

UCONN
STUDENT HEALTH AND WELLNESS

CONSENT FOR TREATMENT:

I hereby authorize Student Health and Wellness (SHaW) and/or Department of Sports Medicine practitioners, employees, and trainees to provide medical and/or mental health services for the treatment of illnesses and injuries, and to arrange for emergency medical care if circumstances render me incapable of making such decision. I understand that I may make informed decisions regarding my treatment, and that I may also refuse any recommended care.

USE AND DISCLOSURE OF HEALTH INFORMATION:

In accepting treatment by any SHaW and/or Department of Sports Medicine provider, I acknowledge that information contained in my treatment records may be disclosed to others beyond treating practitioners as follows or as otherwise required by law and expressly consent to such disclosure:

- *Payment and healthcare operations:* University personnel and external surveyors or experts engaged by the University may have access to health records for such purposes which include health information management, insurance plan eligibility determination, billing, collection and business management activities, quality assessments and medical reviews, and audit or compliance activities.
- *Treatment and health promotion initiatives*: SHaW and Department of Sports Medicine personnel may have access to health records for such purposes which include quality improvement activities and care coordination and referral.
- *Situation involving an imminent threat to health or safety, including to myself or others:* When needed in a psychiatric or medical emergency.
- *Insurance claim*: When information from the treatment record is required to support claims payment.
- *Collaboration with the Student Care Team:* The University is required by law to have a trained threat assessment team. There are times SHaW staff will share medical or mental health information with this team when, in an effort to ensure the safety of the University and its community members, including myself, SHaW deems such limited sharing of information is advisable.
- *Abuse/Neglect:* When required by state law for purposes of mandatory reporting of child, elder, and dependent adult abuse.
- *Connecticut Department of Public Health:* As required by the Regulations of Connecticut State Agencies, the results of certain diagnostic tests are reported to the Connecticut Department of Public Health. These include positive results associated with certain sexually transmitted and other infectious diseases. Additionally, the information associated with a vaccine administered at SHaW may be shared with the Connecticut Department of Public Health.

FINANCIAL RESPONSIBILITY:

I authorize SHaW to submit claims for services provided to my insurance and agree to take responsibility for all balances not covered by insurance or another source of payment. I understand that it is my responsibility to verify that my insurance is in-network with SHaW, and I accept any charges associated with my visit if my insurance is out- of-network.

OTHER NOTICES:

I understand that, where applicable, SHaW providers will develop an individualized plan of care that defines the type and scope of treatment to be provided. The treatment team will be comprised of licensed providers and trainees who will have access to my treatment records. I understand that SHaW has a process by which I may rescind access to my treatment record.

I understand that I may be extended the option to schedule a telehealth appointment. My provider may, at any time, determine that telehealth is no longer appropriate and recommend in-person services. The same confidentiality standards that apply to an in-person visit also apply to a telehealth visit. I understand that I may opt out or refuse telehealth services at any time.

I understand that I may opt to participate in group counseling sessions as part of mental health treatment. Although the information discussed in group sessions is considered confidential by SHaW staff members, confidentiality by other group members cannot be guaranteed. Confidentiality will be discussed and encouraged among all members as a part of group membership.

I understand that my appointments with SHaW mental health trainees may be recorded for the purpose of staff training and clinical supervision. The recordings are treated confidentially and are deleted after they are reviewed.

I understand that e-mail is not a confidential means of communication. I understand that e-mail is not the appropriate way to communicate confidential, urgent, or emergency information.

I understand that SHaW utilizes dedicated electronic equipment including copiers, scanners and faxes to transmit confidential information in a secure manner.

I understand that SHaW has a policy that defines the conditions for the termination of treatment. These conditions include but are not limited to non-compliance with treatment recommendations and major irreconcilable differences between the provider and patient. The professional relationship will not be terminated when the patient is in a physical or emotional crisis. The policy in its entirety can be found on the SHaW website.

Signature(s) below indicates understanding of, and agreement with the above information.

Student Signature: Date:	Parent/Guardian Signature: Date:
Print Student Name:	Print Parent/Guardian Name: If you are under the age of 18 years old, your parent/guardian must sign