WNE CENTER FOR Health & Well-Being

Step 1	Log on to patient portal wne.medicatconnect.com OR Scan QR code to log on to the patient portal
Step 2	From the homepage, go to the Forms section to complete the following forms: • **Consent for Treatment** • **Health History** • **Tuberculosis (TB) Screening Questionnaire** *These forms will need to be completed directly in the patient portal
Step 3	On the homepage, go to the Uploads section and download/print the following forms*: • **Physical Exam** • **Immunization Record** • **TB Test Results** **These forms are attached to this packet for your convenience* To download the forms, select Download under the name of each form
Step 4	Have your medical provider complete and sign the forms with your information making sure to include: • **Your name** • **Your date of birth** • **Date of the exam** • **Whether you are cleared for all school activity**
Step 5	Once complete, upload the completed documents to the patient portal in the Uploads section: • **Go to the Uploads section** • **Choose Select File next to the name of the document you are uploading and choose the appropriate file** • **Once all documents are selected, scroll to the bottom of the page and select the blue Upload button**

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Health Requirements Checklist

Use this checklist to keep track of your submitted health requirements

- ☐ **Tdap**- 1 dose; given within the last 10 years
- ☐ **Hepatitis B-** 3 doses; positive titer proving immunity; or 2 doses of Heplisav-B
- ☐ **MMR**-2 doses; or positive titers proving immunity
- ☐ **Varicella**- 2 doses; or positive titer proving immunity
- ☐ **Meningitis**- 1 dose MenACWY (formerly MCV4) required for students 21 years of age or younger
- ☐ **Physical Exam**- A physical exam completed by a licensed medical provider within 1 year of enrollment
- ☐ **Tuberculosis (TB) Test**- If you answered "yes" to any of the TB screening questions, submit IGRA results or a TB Skin test
- ☐ **Consent for Treatment form (**For 18+ only**)** or **Minor Consent for Treatment form (**for students under 18)
- ☐ **Health History form**

All full time students are required to submit mandatory health requirements. Check out our Connect2U page for more information about program-specific requirements.

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Name _____ Date ofBirth: _____

IMMUNIZATION RECORD

Western New England University requires all the following immunizations whether a resident or commuter unless otherwise stated.

Tetanus-Diphtheria Acellular Pertussis *(Tdap/Adacel within 10 yrs.)*	Month/Day/Yr.___/___/___
MMR Vaccine #1*(on or after the first birthday)*	Month/Day/Yr.___/___/___
MMR Vaccine #2 *(at least 1 month after the first)*	Month/Day/Yr.___/___/___
Hepatitis B Vaccine #1	Month/Day/Yr.___/___/___
Hepatitis B Vaccine #2 *(at least 30 days after the first)*	Month/Day/Yr.___/___/___
Hepatitis B Vaccine #3 *(5 months after the second dose)*	Month/Day/Yr.___/___/___
Varicella Vaccine #1*(at or after 12 months of age)*	Month/Day/Yr.___/___/___
Varicella Vaccine #2 *(given > 4 weeks after the first dose)*	Month/Day/Yr.___/___/___
Meningitis Vaccine MCV4 or MPSV4 *(Required for all students 21 years of age or younger and must be within 5 years of the start of classes)*	Month/Day/Yr.___/___/___ Month/Day/Yr.___/___/___
Meningitis B Vaccine #1 (Bexsero) *(recommended/not required)*	Month/Day/Yr.___/___/___
Meningitis B Vaccine #2 *(> 1 month after the first dose)*	Month/Day/Yr.___/___/___
COVID-19 Vaccines *(strongly recommended- not required)* *Required for all PharmD and MSPGx (online and on campus)*	Month/Day/Yr.___/___/___ Month/Day/Yr.___/___/___ Month/Day/Yr.___/___/___ Month/Day/Yr.___/___/___

If proof of immunization for measles, mumps, rubella, Hepatitis B or Varicella is not available a blood titer immunity proven by laboratory confirmation will be accepted. **Please** upload titer results.

Print or Stamp

Provider'sName_____Address_____Phone_____

Signature _____ MD/DO/NP Date _____

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Physical Examination

1. The physical examination date can be no earlier than 1 year prior to the first day of classes and for athletes no earlier than 6 months prior (NCAA)
2. Completed forms should be uploaded to the health portal (https://wne.medicatconnect.com/home.aspx)

Name_____Date ofBirth:_____

Height_____Weight_____BP_____Pulse_____Vision R 20/_____L 20/_____ Corrected Yes/No

	Normal	Abnormal Findings
Appearance (Marfan stigmata)		
Skin		
Eyes, Head, Ears, Nose, Throat		
Respiratory		
Cardiovascular		
Gastrointestinal/Hernia		
Genitourinary		
Musculoskeletal		
Metabolic/Endocrine		
Neurological, Psychiatric		
Functional mobility		

Is there any reason this student should not participate in sports or rigorous activities? Yes No Specify

Is the patient now under treatment for emotional or psychological conditions? Yes No Specify

Do you have any recommendations regarding the care of this student? Yes No Specify

Print or Stamp

Provider'sName_____Address_____Phone_____

Signature _____MD/DO/NP DateofExam _____

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TUBERCULOSIS TESTING

Name _____Date of Birth _____Date_____

If you had a positive TB screening, please complete one of the following: Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA).

Tuberculin Skin Test (TST):	**Interferon Gamma Release Assay (IGRA)/ QuantiFERON Gold**
Administered: ____/ ___/_____ Time: _____	**Date Obtained: ____/ ___/_____**
Date Read: _____/ ____/_____ Time: _____	**Result: positive _____negative____**
Result: _____mm of induration **	**Indeterminate_____**
Interpretation: positive _____negative____	

Name of health care professional (print or type): _____

Address: _____ Phone: _____

Signature: _____MD/DO/NP/PA