Please return to: University Medical Specialties
9045 U.S. 31, Berrien Springs MI 49104-0960
Phone: 269-473-2222
Fax: 269-473-6880
Email: studenthealth@andrews.edu

PERSONAL INFORMATION

(print legibly)

U.S. Social Security Number *(if applicable)* ☐☐☐–☐☐–☐☐☐☐ Andrews ID Number *(if known)* _____

Last/Family Name _____ First name _____

Home Address: Street _____

City _____ State _____ Zip Code _____ Country _____

Home Phone _____ Mobile Phone _____

Email Address _____

Gender ☐ Male ☐ Female **Birth Date:** MM/DD/YYYY _____

Level ☐ Undergraduate ☐ Graduate **Anticipated term of enrollment** ☐ Fall ☐ Spring ☐ Summer **Year** _____

Where do you plan to live? ☐ Residence Hall ☐ University Apartment ☐ Off-campus

Have you attended Andrews before? ☐ No ☐ Yes: from MM/YYYY _____ to MM/YYYY _____

HEALTH CARE PROVIDER MUST COMPLETE: *REQUIRED*

To protect your health, and to be in compliance with the Michigan Department of Public Health and the Advisory Council on Immunization Practices, Andrews University REQUIRES proof of vaccination or immunity to measles, mumps and rubella, as well as evaluation for tuberculosis PRIOR to registration. For questions email studenthealth@andrews.edu.

M.M.R.

Two doses required
(estimated cost $115 if done on-campus)

DOSE 1: Given at age 12 months or later M/D/Y _____ / _____ / _____

DOSE 2: Given at age 4–6 or later M/D/Y _____ / _____ / _____

—OR—

MMR Titer (attach copy) M/D/Y _____ / _____ / _____

RESULTS ☐ Immune ☐ Non-immune

Tuberculosis (TB) Screening

Required within 6 months prior to registration
(estimated cost $20 if done on-campus)

TB Skin Test M/D/Y _____ / _____ / _____

RESULTS ☐ Negative ☐ Postive

MM of in duration _____ ☐ Unknown

BCG Given ☐ Yes ☐ No ☐ Unkonwn

Chest X-Ray

Required within one year only if TB skin test is positive

Chest X-ray Date M/D/Y _____ / _____ / _____

Chest X-ray results ☐ Positive, evidence of active TB

☐ Negative ☐ Negative, evidence of inactive TB

continued

HEALTH CARE PROVIDER MUST COMPLETE: *RECOMMENDED*

The following vaccinations are recommended. You should discuss these with your physician or other health care provider.
Individual vaccination may be required as a prerequisite to clinical rotations (HEPATITIS B), or encouraged, if injured (TETANUS).
This list does not include immunization that may be recommended only as a part of study or travel abroad.

Tetanus-Diphtheria

Primary series with DTaP or DTP and booster at 4–6 year and every 10 years thereafter

DOSE 1: M/D/Y ____ / ____ / ____ DOSE 2: M/D/Y ____ / ____ / ____

DOSE 3: M/D/Y ____ / ____ / ____ DOSE 4: M/D/Y ____ / ____ / ____

Tdap Booster (within 10 years) M/D/Y ____ / ____ / ____

☐ Immunization likely, no records ☐ Not immunized

Polio

Primary series of 3 (oral) or 4 (injectable) doses plus a booster during childhood

DOSE 1: M/D/Y ____ / ____ / ____ DOSE 2: M/D/Y ____ / ____ / ____

DOSE 3: M/D/Y ____ / ____ / ____ DOSE 4: M/D/Y ____ / ____ / ____

Booster (within 10 years) M/D/Y ____ / ____ / ____

☐ Immunization likely, no records ☐ Not immunized

Hepatitis B

Three doses of vaccine or a positive Hepatitis B Surface Antibody (HBSAb)

DOSE 1: M/D/Y ____ / ____ / ____ DOSE 2: M/D/Y ____ / ____ / ____

DOSE 3: M/D/Y ____ / ____ / ____

Hepatitis B Surface Antibody (attach copy) M/D/Y ____ / ____ / ____

RESULTS ☐ Immune ☐ Non-immune

☐ Immunization likely, no records ☐ Not immunized

Varicella

History of chickenpox, or a positive varicella antibody titer, or two doses of vaccine at least one month apart (if immunized after age 13) indicates immunity

History of disease ☐ Yes ☐ No

Vaccination M/D/Y ____ / ____ / ____

*Booster M/D/Y ____ / ____ / ____

**At least one month after 1st does if given after age 13*

Varicella Antibody M/D/Y ____ / ____ / ____

☐ Immunization likely, no records ☐ Not immunized

Meningococcus

Recommended for freshman students, age 25 and below, living in a residence hall and for individuals with immunodeficiency or who have had a splenectomy

Vaccination M/D/Y ____ / ____ / ____

☐ Immunization likely, no records ☐ Not immunized

Influenza

Annual immunization, in the late fall, recommended to avoid disruption to academic responsibilities and strongly recommended for those with diabetes, asthma, heart disease, and certain other chronic diseases.

Vaccination M/D/Y ____ / ____ / ____

☐ Immunization likely, no records ☐ Not immunized

HEALTH CARE PROVIDER CONTACT INFORMATION

Last/Family Name _____ First name _____

Street Address _____

City _____ State _____ Zip Code _____ Country _____

Phone _____ Fax Number _____

Signature _____ Date _____