JOHNS HOPKINS UNIVERSITY

**Homewood Student Affairs**
Student Health
& Wellness Center

**OFFICE USE ONLY:**

☐(BB) Rec'd ☐Insurance
☐(BB) Complete ☐SIS
☐Imaged

# Pre-Entrance Health Form
# (AS/EN/PY)

☐**Step 1**. Complete this form as indicated. **Please make a copy of these forms for your own records**

☐**Step 2**. Register for the PyraMed Health WebPortal http://www.shwcportal.jhu.edu/PyramedPortal and complete 3 online forms:

- Health History, Immunization, and Consent to Medical Procedure

☐**Step 3**. Submit this form using one of the methods provided below:

- Mail or Drop off: JHU Student Health & Wellness Center, 1 E 31st Street, N200, Baltimore, MD 21218
- Fax: 410-516-4784 (include cover page with student's full name, school, and date of birth)
- Email: healthforms@jhu.edu (attach form as a PDF; **do not** submit photographed images of your form)

**IMPORTANT: Failure to comply will result in a $100 fee and will block you from adding or dropping classes.**

**DUE: May 30th (Early Arrivals)** **July 15th (Fall Admission)** **January 15th (Spring Admission)**

## Part 1: General Information (REQUIRED)

**Name** :_____ _____ _____**Date of Birth**:____/____/_____
(Last or Family Name) (First or Given Name) (Middle Name) Month Day Year

**Hopkins ID** (6 characters; found in SIS): _____ **Email Address** (JHU preferred): _____

**Home Phone** (USA): _____ **Student Cell Phone**: _____
Including Area Code Including Area Code

**Country of birth**: ☐ United States ☐ Other country (please specify): _____

**Initial Term Entering JHU**: ☐Fall _____ ☐ Spring _____ **Status:** ☐ Homewood Undergrad ☐ Homewood Grad.
Year Year ☐ Peabody ☐ Transfer ☐ Other

## Part 2: Immunization Records – (To be completed and signed by your health care provider OR in lieu of their signature you may attach a copy of your official immunization record to this form.)

**Required Immunizations (A-F):**

**A-D. Measles, Mumps and Rubella (MMR) Vaccine:** 2 doses of MMR OR 2 doses of measles & mumps PLUS 1 dose of rubella OR positive blood titers. All doses must be administered at 12 months of age or older.

| | Dose 1 | Dose 2 | Titer | Result *(circle one)* |
|---|---|---|---|---|
| **A. MMR (Measles, Mumps, Rubella)** | ____/____/_____ Mo. Day Year | ____/____/_____ Mo. Day Year | | |
| **B. Measles,** *if given individually OR date and result of immune titer* | ____/____/_____ Mo. Day Year | ____/____/_____ Mo. Day Year | ____/____/_____ Mo. Day Year | Negative / Positive |
| **C. Mumps,** *if given individually OR date and result of immune titer* | ____/____/_____ Mo. Day Year | ____/____/_____ Mo. Day Year | ____/____/_____ Mo. Day Year | Negative / Positive |
| **D. Rubella,** *if given individually OR date and result of immune titer* | ____/____/_____ Mo. Day Year | ____/____/_____ Mo. Day Year | ____/____/_____ Mo. Day Year | Negative / Positive |
| **E. Tdap (tetanus, diphtheria and pertussis) vaccine for adults:** Must be given at age 10 or older. Td (Tetanus-diphtheria) does not satisfy this requirement. Do not confuse the adult Tdap with the DTaP vaccine given before age 7. | | | ____/____/_____ Mo. Day Year | |

**F. Meningococcal Vaccine:** Under Maryland law, students who reside on-campus are required to have one dose of the 4-valent (ACYW) meningococcal conjugate vaccine **at age 16 or older,** or you must sign the waiver.

| **Date of vaccination:** ____/____/____ Mo. Day Year | **Type of vaccine given:** ☐ **Menactra** ☐ **Menveo** ☐**Other:**_____ |
|---|---|

**Waiver/Declination to receive immunization**

☐ I have read the meningitis information available from the SHWC website. I understand the possible detrimental effects of meningococcal disease (meningitis) and acknowledge that I have received information about the availability of the meningococcal vaccine. I do not wish to receive the vaccine and I voluntarily agree to release, discharge, indemnify and hold harmless, Johns Hopkins University, its officers, employees and agents from any and all costs, liabilities, claims, demands, or causes of action on account of any loss or personal injury that might result from my waiving the vaccine. I have read and signed this document with full knowledge of its significance. I further state that I am at least 18 years of age and competent to sign this waiver or a parent/guardian must sign.

**Signature:**_____ **Date:** _____

**Parent Signature (if under 18 years of age) :**_____ **Date:** _____

**Non-Required Immunizations (G-M):**

| | | | | | |
|---|---|---|---|---|---|
| **G. Human Papillomavirus (HPV)** *(3 dose series)* | **Dose 1** ____/____/____ Mo. Day Yr. | **Dose 2** ____/____/____ Mo. Day Yr. | **Dose 3** ____/____/____ Mo. Day Yr. | | |
| **H. Group B Meningitis** ☐Bexsero ☐ Trumenba | **Dose 1** ____/____/____ Mo. Day Yr. | **Dose 2** ____/____/____ Mo. Day Yr. | **Dose 3** ____/____/____ Mo. Day Yr. | | |
| **I. Varicella (chicken pox):** 2 doses of varicella or provide approximate date of disease. | **Dose 1** ___/___/___ Mo. Day Yr. | **Dose 2** ___/___/___ Mo. Day Yr. | **OR** | **Varicella Illness** ___/___ Mo. Yr. | |
| **J. Polio** Completed primary series: ☐Yes ☐ No **Date of last dose**: ____/____/____ Mo. Day Yr. | | | | | |
| **K. Hepatitis B** *(3 dose series)* | **Dose 1** ____/____/____ Mo. Day Yr. | **Dose 2** ____/____/____ Mo. Day Yr. | **Dose 3** ____/____/____ Mo. Day Yr. | | |
| **L. Hepatitis A** *(2 dose series)* | **Dose 1** ____/____/____ Mo. Day Yr. | **Dose 2** ____/____/____ Mo. Day Yr. | | | |
| **M. Td (Tetanus-diphtheria)** *if you received a Tdap (see section E) and have subsequently received a Td booster* | **Dose 1** ____/____/____ Mo. Day Yr. | | | | |

**Part 3: Tuberculosis Risk Assessment**

Have you ever spent 4 consecutive weeks or longer in any of the following **areas with a high incidence rate of tuberculosis** as defined by the World Health Organization?:

**Angola, Bangladesh, Brazil, Cambodia, Central African Republic, China, DR Congo, Congo, Ethiopia, Guatemala, Haiti, Hong Kong, India, Indonesia, Kenya, DPR Korea, Korea, Lesotho, Liberia, Mexico, Mozambique, Myanmar, Namibia, Nigeria, Pakistan, Papua New Guinea, Philippines, Russian Federation, Sierra Leone, South Africa, Taiwan, Tanzania, Thailand, Viet Nam, Zambia, Zimbabwe**

☐ **No**.→ You can skip this section.

☐ **Yes**.→ TB screening via blood test is required within 6 months prior to your arrival on campus.

**Type of test**

**A. Blood Test, must be completed within 6 months prior to your arrival on campus.**
(Please provide a copy of the lab report in English. If result is indeterminate, repeat the test for conclusive result)

| Date of test | Type of test administered | Result(circle one) |
|---|---|---|
| ____/____/____ Mo. Day Year | ☐**QuantiFERON®-TB Gold** ☐**T-SPOT ®** | Positive / negative |

B. **If positive blood test, a chest x-ray is required within 6 months prior to your arrival on campus.**

| Date of chest x-ray | Date of Result | *If abnormal, a*ttach a copy of chest x-ray report in English. |
|---|---|---|
| ____/_____/_____<br>Mo. Day Year | ____/_____/_____<br>Mo. Day Year | ☐**Normal**<br>☐**Abnormal** |

**C. If you screened positive for TB, have you received treatment for latent TB?**

☐ No ☐ Yes→ provide dates and the name of the medication below.

| Start Date | Stop date | Name of Medication |
|---|---|---|
| ____/____/____<br>Mo. Day Year | ____/____/____<br>Mo. Day Year | _____ |

**Health Care Provider Information:** I have reviewed all of the information on this form and **certify that it is complete and accurate**.

Provider Name: _____ Date: _____

Address: _____ Telephone: _____

Signature/Stamp : _____

**Part 4: Consent to treatment - Parent Signature required if under age 18**

I/We hereby authorize the professional staff of the Homewood Student Health and Wellness Center of The Johns Hopkins University and /or any one of the Deans and/or the Director or official coaches of the Department of Athletics & Recreation of said University, in the event I/we shall not be readily available in connection with the need for the consent hereinafter referred to, to consent to, and authorize, in my/our behalf, medical treatment and/or the performing of any operative and surgical procedure and under any anesthetic, either local or general, for myself/our son/daughter, (Name of student) _____ while a student at said University, as may be considered necessary or advisable by the physician performing such treatment or surgery, and/or to release to other physicians who may be treating me/our son/daughter, relevant medical information as to treatment accorded me/him/her through the University's Student Health and Wellness Center.

The laws of Maryland require that surgical and medical treatment of minors (individuals less than 18 years of age) be at the request of and with the approval of their parents (and spouse of a married minor). The right to request and approve may be delegated to officials of the University. It is our policy to notify parents as soon as possible in the event of major illness or injury. We find it impractical to notify for every minor illness or injury requiring treatment. It will help us to protect the health of your son or daughter if you will delegate to us discretion in these matters.

Requests are received from hospitals, other physicians, other universities, and insurance companies for information about conditions treated by us. Parents of minors (and spouse of a married minor) must approve the release of such information and may delegate this discretion to physicians of the Student Health and Wellness Center. It is our policy to disclose medical information at the request of the student in the belief that it will be used for ordinary medical and insurance purposes.

**Parent Signature (if under 18 years of age):**_____ **Date:** _____

**Part 5: Health Insurance Information**

All students are automatically enrolled in the JHU Student Health Benefits Plan. If you have waived the JHU Student Health Benefits Plan, ***please provide a copy of the front and back of your insurance card,*** and complete the insurance information below.

Insurance Company: _____Phone #:_____Exp. Date:_____

Address:_____

Policy Holder:_____ Policy #:_____ Group #:_____

**Preferred/Required laboratory *(if applicable)***: ☐ Quest ☐ LabCorp ☐ other: _____