JOHNS HOPKINS UNIVERSITY | **Homewood Student Affairs** Student Health & Wellness Center

OFFICE USE ONLY:

☐ Rec'd ☐ Insurance
☐ Complete ☐ Imaged

Pre-Entrance Health Form (Post-Doctoral Fellows)

☐ **Step 1**. Complete this form as indicated. **Please make a copy of these forms for your own records**
☐ **Step 2**. Email Brittney Dawson (bdawson8@jhu.edu) your name, date of birth, Hopkins ID and signed appointment letter so you can be added to Student Health Center data base.
☐ **Step 3.** Register for the Health WebPortal http://www.shwcportal.jhu.edu/PyramedPortal and complete 5 online forms.
☐ **Step 4**. 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 your full name, department & date of birth)
- Email: healthforms@jhu.edu (attach form as PDF; **do not** submit photographed images of your form)

IMPORTANT: Failure to comply prior to arrival on campus: **Blocked from utilizing the SHWC services.**

DUE: One month prior to appointment start date

Part 1: General Information (REQUIRED)

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

Gender: ☐ Female ☐ Male **Hopkins ID** (6 characters/not email): ___________________

Email Address (JHU preferred): ______________________________ **Student U.S. Cell Phone**: ____ Including Area Code

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

School: ☐ Arts & Sciences ☐ Engineering ☐ School of Education **Appointment period**: ____/____/____ through: ____/____/_____ MM/DD/YYYY MM/DD/YYYY

Part 2: Immunizations (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-E):

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 11 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

Student Name: ______________________________ Date of Birth: ____________

Non-required Immunizations (F-K):

	Immunization				
F.	**Human Papillomavirus (HPV)** recommended up to age 26 *(3 dose series)*	**Dose 1** ____/____/____ Mo. Day Yr.	**Dose 2** ____/____/____ Mo. Day Yr.	**Dose 3** ____/____/____ Mo. Day Yr.	
G.	**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.
H.	**Polio** Completed primary series: ☐Yes ☐ No	**Date of last dose**: ____/____/____ Mo. Day Yr.			
I.	**Hepatitis B** *(3 dose series)*	**Dose 1** ____/____/____ Mo. Day Yr.	**Dose 2** ____/____/____ Mo. Day Yr.	**Dose 3** ____/____/____ Mo. Day Yr.	
J.	**Hepatitis A** *(2 dose series)*	**Dose 1** ____/____/____ Mo. Day Yr.	**Dose 2** ____/____/____ Mo. Day Yr.		
K.	**Td (Tetanus-diphtheria)** *if you received a Tdap (see section E) and have subsequently received a Td booster*	**Dose 1** ____/____/____ Mo. Day Yr.			

Tuberculosis Risk Assessment Have you ever:

- Had close contact with persons known or suspected to have active tuberculosis?
- Been a resident, employee, or volunteer in a high risk congregate setting (e.g. correctional facility, long-term care facility, or homeless shelter)?
- Been a volunteer or health care worker who served clients at increased risk for active tuberculosis?
- **Spent 4 consecutive weeks or longer in any of the following areas with a high incidence rate of tuberculosis?** :

Afghanistan, **Algeria**, **Angola**, **Anguilla**, **Argentina**, **Armenia**, **Azerbaijan**, **Bangladesh**, **Belarus**, **Belize**, **Benin**, **Bhutan**, **Bolivia**, **Bosnia & Herzegovina**, **Botswana**, **Brazil**, **Brunei**, **Bulgaria**, **Burkina Faso**, **Burundi**, **Cabo Verde**, **Cambodia**, **Cameroon**, **Central African Republic**, **Chad**, **China**, **China, Macao SAR**, **Colombia**, **Comoros**, **Congo**, **Cote d'Ivoire**, **Democratic People's Republic of Korea**, **Democratic People's Republic of the Congo**, **Djibouti**, **Dominican Republic**, **Ecuador**, **El Salvador**, **Equatorial Guinea**, **Eritrea**, **Eswatini**, **Ethiopia**, **Fiji**, **French Polynesia**, **Gabon**, **Gambia**, **Georgia**, **Ghana**, **Greenland**, **Guam**, **Guatemala**, **Guinea**, **Guinea-Bissau**, **Guyana**, **Haiti**, **Honduras**, **Hong Kong**, **India**, **Indonesia**, **Iraq**, **Kazakhstan**, **Kenya**, **Kiribati**, **Kuwait**, **Kyrgyzstan**, **Lao People's**, **Latvia**, **Lesotho**, **Liberia**, **Libya**, **Lithuania**, **Madagascar**, **Malawi**, **Malaysia**, **Maldives**, **Mali**, **Marshall Isl.**, **Mauritania**, **Mexico**, **Micronesia**, **Mongolia**, **Morocco**, **Mozambique**, **Myanmar (Burma)**, **Namibia**, **Nauru**, **Nepal**, **Nicaragua**, **Niger**, **Nigeria**, **Niue Nrth. Mariana Isl.**, **Pakistan**, **Palau**, **Panama**, **Papua New Guinea**, **Paraguay**, **Peru**, **Philippines**, **Portugal**, **Qatar**, **Rep of Korea**, **Rep of Moldova**, **Romania**, **Russian Fed**, **Rwanda**, **Sao Tome & Principe**, **Senegal**, **Sierra Leone**, **Singapore**, **Solomon Isl.**, **Somalia**, **South Africa**, **South Sudan**, **Sri Lanka**, **Sudan**, **Suriname**, **Tajikstan**, **Thailand**, **Timor-Leste**, **Togo**, **Tokelau**, **Trinidad &Tobago**, **Tunisia**, **Turkmenistan**, **Tuvalu**, **Uganda**, **Ukraine**, **United Rep of Tanzania**, **Uruguay**, **Uzbekistan**, **Vanuatu**, **Venezuela**, **Viet Nam**, **Yemen**, **Zambia**, **Zimbabwe**

☐ **No.**→ If you answered *no* to any of the aforementioned questions, then you can skip this section.
☐ **Yes.**→ If you answered *yes* to any of the aforementioned questions then, TB screening via blood test is required.

Type of test (we only accept the blood test)

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

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 arrival on campus**

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

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

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

Start Date	Stop date	Name of Medication
___/___/___ Mo. Day Year	___/___/___ 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: ______________________

Provider Signature/Stamp**:** ____