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 Stephanie Bryant (sbryan22@jhu.edu) your name, date of birth, Hopkins/JHED ID and signed appointment letter.
☐ **Step 3.** 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 4**. Submit your form

- 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 will result in a $100 fee and will block you from utilizing the SHWC services

DUE: One month prior to appointment start date

General Information

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

Hopkins ID (6 characters): ______________________ **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): ____

Appointment period: ____/____/____ through: ____/____/_____ **Status:** ☐ Post-doctoral fellow
MM/DD/YYYY MM/DD/YYYY

Immunizations - Complete in English & have it signed by your health care provider OR attach a copy of your official immunization record.

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 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

Non-required Immunizations (F-K):

	Dose 1	Dose 2	Dose 3
F. Human Papillomavirus (HPV) recommended up to age 26 *(3 dose series)*	____/____/____ Mo. Day Yr.	____/____/____ Mo. Day Yr.	____/____/____ 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)*	____/____/____ Mo. Day Yr.	____/____/____ Mo. Day Yr.	____/____/____ Mo. Day Yr.
J. Hepatitis A *(2 dose series)*	____/____/____ Mo. Day Yr.	____/____/____ Mo. Day Yr.	
K. Td (Tetanus-diphtheria) *if you received a Tdap (see section E) and have subsequently received a Td booster*	____/____/____ Mo. Day Yr.		

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 and the American College Health Association ?:

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 arrival on campus**

Date of chest x-ray	Date of Result	***If abnormal,* attach 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: ________________

Signature/Stamp : ____