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

Non-required Immunizations (F-K):

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 Democratic Republic, 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 all 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**:** _____