JOHNS HOPKINS UNIVERSITY | Student Health & Well-Being

OFFICE USE ONLY:

☐ Rec'd ☐ Complete **EHP insurance**

Pre-Entrance Health Form for Post-Doctoral Fellows

☐**Step 1**. Complete this form as indicated, signed by your doctor's office or with attachments of vaccine history record to verify the dates you list. **Save to your desktop as PDF or JPG.**

☐**Step 2**. Email Linda Zeigler (lzeigle2@jhu.edu) the form and necessary attachments, your Hopkins/SIS ID and signed appointment letter in order for you to be added to the JHU Student Health & Wellness Center data base.

☐**Step 3**. Once you have your SIS/Hopkins ID (ask your department administrator), please email Linda so that she can update your record at Student Health and then you can complete the required online health web portal forms.

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

DUE: 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:** ____/____/____ MM/DD/YYYY through: ____/____/____ 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 or vaccine history records to this form. **Save as PDF or JPG for upload to the online health web portal Immunization 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 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

F. COVID-19

Date of Vaccine #1: ____/____/____ **Manufacturer: ☐ Moderna ☐ Novavax ☐ Pfizer ☐ Johnson & Johnson ☐ AstraZeneca ☐ Other**
Mo. Day Yr.

Date of Vaccine #2: ____/____/____ **Manufacturer: ☐ Moderna ☐ Novavax ☐ Pfizer ☐ Johnson & Johnson ☐ AstraZeneca ☐ Other**
Mo. Day Yr.

Date of Vaccine #3: ____/____/____ **Manufacturer: ☐ Moderna ☐ Novavax ☐ Pfizer ☐ Johnson & Johnson ☐ AstraZeneca ☐ Other**
Mo. Day Yr.

Non-required Immunizations (G-M):

G. Human Papillomavirus (HPV)	**Dose 1** ____/____/____ Mo. Day Yr.	**Dose 2** ____/____/____ Mo. Day Yr.	**Dose 3** ____/____/____ Mo. Day Yr.
H. Group B Meningitis ☐ **Be**xsero ☐ 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: ☐ **Y**es ☐ 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 *booster* (Tetanus-diphtheria) *ONLY add a date here if you received a Tdap (see section E) and have subsequently received a Td booster*	**Dose 1** ____/____/____ Mo. Day Yr.		

FLU VACCINE – 2022-2023 Seasonal Vaccine for Influenza

Johns Hopkins University **requires the flu vaccine of the current flu season** for all students, and there will be opportunity to obtain the vaccine at flu clinics on campus this fall.

Only if you have received the current season's flu vaccine, given **AFTER AUGUST 1, 2022**, write a date.
Otherwise, please leave blank.

_____ /_____/ _____
Mo. Day Yr.

Part 3: 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?
- **Been born in, or spent 4 consecutive weeks or longer** in **any of the following areas** with a high incidence rate of tuberculosis (defined as countries with incidence rates of ≥ 20 cases of TB per 100,000 population, http://www.who.int/tb/country/en/)

Afghanistan	Cameroon	Gabon	Lesotho	Nigeria	South Sudan
Algeria	Central African Republic	Gambia	Liberia	Northern Mariana Islands	Sri Lanka
Angola	Chad	Georgia	Libya	Pakistan	Sudan
Anguilla	China	Ghana	Lithuania	Palau	Suriname
Argentina	China, Hong Kong SAR	Greenland	Madagascar	Panama	Tajikistan
Armenia	China, Macao SAR	Guam	Malawi	Papua New Guinea	Thailand
Azerbaijan	Colombia	Guatemala	Malaysia	Paraguay	Timor-Leste
Bangladesh	Comoros	Guinea	Maldives	Peru	Togo
Belarus	Congo	Guinea-Bissau	Mali	Philippines	Tokelau
Belize	Côte d'Ivoire	Guyana	Marshall Islands	Qatar	Tunisia

Benin	Democratic People's Republic of Korea	Haiti	Mauritania	Republic of Korea	Turkmenistan
Bhutan	Democratic Republic of the Congo	Honduras	Mexico	Republic of Moldova	Tuvalu
Bolivia	Djibouti	India	Micronesia	Romania	Uganda
Bosnia & Herzegovina	Dominican Republic	Indonesia	Mongolia	Russian Federation	Ukraine
Botswana	Ecuador	Iraq	Morocco	Rwanda	United Republic of Tanzania
Brazil	El Salvador	Kazakhstan	Mozambique	Sao Tome & Principe	Uruguay
Brunei Darussalam	Equatorial Guinea	Kenya	Myanmar	Senegal	Uzbekistan
Bulgaria	Eritrea	Kiribati	Namibia	Sierra Leone	Vanuatu
Burkina Faso	Eswatini	Kuwait	Nauru	Singapore	Venezuela
Burundi	Ethiopia	Kyrgyzstan	Nepal	Solomon Islands	Viet Nam
Cabo Verde	Fiji	Lao People's Democratic Republic	Nicaragua	Somalia	Yemen
Cambodia	French Polynesia	Latvia	Niger	South Africa	Zambia
					Zimbabwe

☐ **No.**→ If you answered ***no* to all** of the aforementioned questions, you can skip this section.
☐ **Yes.→ If you answered *yes* to any of the aforementioned questions, 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 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.
____/_____/_____ 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 the medication below.

Start Date	Stop date	Name of Medication
____/____/____ Mo. Day Year	____/____/____ Mo. Day Year	_____

In following the AMA Code of Medical Ethics 1.2.1,
The JHU SHWC will not accept any medical forms completed by a medical clinician family member.

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: _____

OR, in lieu of health care provider signature, ATTACH VACCINE HISTORY RECORD to verify dates listed on this form.