JOHNS HOPKINS UNIVERSITY | Student Health & Well-Being

**OFFICE USE ONLY:**

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

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

☐**Step 1**. Complete this form as indicated. **Save to your desktop as PDF or JPG.**
☐**Step 2**. Register to access the online Health WebPortal http://www.shwcportal.jhu.edu/PyramedPortal and complete forms.
☐**Step 3**. Upload this saved form (signed by medical provider or with attached vaccine history records) to the online portal form called PRE- ENTRANCE IMMUNIZATION HEALTH FORM.

**IMPORTANT:** Failure to complete ALL steps prior to your arrival on campus will result in a $100 Health Form Completion Fee, possible orientation interruption & you will be blocked from adding or dropping classes.

**DUE: May 30 (Early arrivals) July 15 (Fall admission) January 15 (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/Year Entering JHU**: **Status:** ☐ Homewood UG ☐ Homewood Grad ☐ Visiting Grad ☐ Post-Bacc
☐ Fall _____ ☐ Spring _____ ☐ Education ☐ Peabody ☐ Homewood UG Transfer ☐ Exchange student

**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 record to this form. **Save as PDF or JPG for upload to the online health web portal Immunization form**.

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

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

**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:** _____

**G. COVID-19**

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

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

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

**H.**

**Non-Required Immunizations (H-N):**

| | | | | | |
|---|---|---|---|---|---|
| **I. Human Papillomavirus (HPV)** | **Dose 1** _____/_____/_____ Mo. Day Yr. | **Dose 2** _____/_____/_____ Mo. Day Yr. | **Dose 3** _____/_____/_____ Mo. Day Yr. | | |
| **J. Group B Meningitis** ☐Bexsero ☐ Trumenba | **Dose 1** _____/_____/_____ Mo. Day Yr. | **Dose 2** _____/_____/_____ Mo. Day Yr. | **Dose 3** _____/_____/_____ Mo. Day Yr. | | |
| **K. 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. | |
| **L. Polio:** Completed primary series: ☐Yes ☐ No **Date of last dose**: ____/____/____ Mo. Day Yr. | | | | | |
| **M. Hepatitis B** *(3 dose series)* | **Dose 1** _____/_____/_____ Mo. Day Yr. | **Dose 2** _____/_____/_____ Mo. Day Yr. | **Dose 3** _____/_____/_____ Mo. Day Yr. | | |
| **N. Hepatitis A** *(2 dose series)* | **Dose 1** _____/_____/_____ Mo. Day Yr. | **Dose 2** _____/_____/_____ Mo. Day Yr. | | | |
| **O. 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 | Chad | Georgia | Madagascar | Palau | Tajikistan |
| Algeria | China | Ghana | Malawi | Panama | Thailand |
| Angola | China, Hong Kong SAR | Greenland | Malaysia | Papua New Guinea | Timor-Leste |
| Anguilla | China, Macao SAR | Guam | Maldives | Paraguay | Togo |
| Argentina | Colombia | Guatemala | Mali | Peru | Tokelau |
| Armenia | Comoros | Guinea | Malta | Philippines | Tunisia |
| Azerbaijan | Congo | Guinea-Bissau | Marshall Islands | Qatar | Turkmenistan |
| Bangladesh | Côte d'Ivoire | Guyana | Mauritania | Republic of Korea | Tuvalu |
| Belarus | Democratic People's Republic of Korea | Haiti | Mexico | Republic of Moldova | Uganda |
| Belize | Democratic Republic of the Congo | Honduras | Micronesia | Romania | Ukraine |
| Benin | Djibouti | India | Mongolia | Russian Federation | United Republic of Tanzania |
| Bhutan | Dominica | Indonesia | Morocco | Rwanda | Uruguay |
| Bolivia | Dominican Republic | Iraq | Mozambique | Sao Tome & Principe | Uzbekistan |
| Bosnia & Herzegovina | Ecuador | Kazakhstan | Myanmar | Senegal | Vanuatu |
| Botswana | El Salvador | Kenya | Namibia | Sierra Leone | Venezuela |
| Brazil | Equatorial Guinea | Kiribati | Nauru | Singapore | Viet Nam |
| Brunei Darussalam | Eritrea | Kyrgyzstan | Nepal | Solomon Islands | Yemen |
| Burkina Faso | Eswatini | Lao People's Democratic Republic | Nicaragua | Somalia | Zambia |
| Burundi | Ethiopia | Latvia | Niger | South Africa | Zimbabwe |
| Cabo Verde | Fiji | Lesotho | Nigeria | South Sudan | |
| Cambodia | French Polynesia | Liberia | Niue | Sri Lanka | |
| Cameroon | Gabon | Libya | Northern Mariana Islands | Sudan | |
| Central African Republic | Gambia | Lithuania | Pakistan | Suriname | |

☐ **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 blood test** (we **only** accept the blood test)

**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) |
|---|---|---|
| ____/_____/_____<br>Mo. Day Year | ☐ **QuantiFERON®-TB Gold**<br>☐ **T-SPOT ®** | Positive / negative |

ONLY IF YOU HAVE a **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 |

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/stamp, ATTACH VACCINE HISTORY RECORDS to verify dates listed on this form when you attach/upload the form to the online portal health form called Pre Entrance Immunization form.**

**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:** _____