JOHNS HOPKINS UNIVERSITY

OFFICE USE ONLY:

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The Student Health and Wellness Center • 1 E. 31st Street, N200 • Baltimore, Maryland 21218
Phone: 410-516-8270 Fax: 410-516-4784

POST-DOCTORAL PRE-ENTRANCE HEALTH FORM

ALL incoming Homewood Campus Post-doctoral fellows who wish to utilize the SHWC services are REQUIRED to provide proof of immunity to certain communicable diseases and complete the steps as outlined below:

☐ 1. Have your health care provider complete & sign this pre-entrance health form (do not submit until you have completed step 2).
☐ 2. Then, register for the PyraMed Health WebPortal http://www.shwcportal.jhu.edu/PyramedPortal and complete the three online pre-entrance health forms (Health History, Immunization, and Consent to Medical Procedure).
☐ 3. Submit the signed health form and any other documents to the Student Health and Wellness Center.

Acceptable ways to submit your health form:

Mailing or Drop off: JHU Student Health & Wellness Center, 1 E. 31st Street, N200, Baltimore, MD 21218
Fax: 410-516-4784 (please include cover page with student's full name, school and date of birth)
Email: healthforms@jhu.edu (attach health form as PDF; please do not submit photographed images of your health form)

IMPORTANT: Online health forms **must** be completed prior to submitting this form. Failure to complete online forms prior to health form submission will **significantly delay the processing**. Please *carefully* read this health form in its entirety and complete all required sections. **Failure to comply with pre-entrance health requirements prior to your arrival on campus will result in a $100 health form completion fee and will block you from utilizing the SHWC services.**

DUE: One month prior to appointment start date

General Information (fill out information below in its entirety)

Student:_____ **Date of Birth**: ___/____/_____
(Last Name) (First Name) (Middle Name) Month Day Year

Gender: ☐ Male ☐ Female ☐ Transgender **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

MAKE A COPY OF THESE FORMS FOR YOUR OWN RECORDS. WE CANNOT GUARANTEE THE ARRIVAL OF MAILED FORMS.

Allow 5 business days for your records to be received, reviewed and processed after submitting.

This pre-entrance health form must be completed in English & signed by your health care provider. **No physical examination is required**! You may attach a copy of your official immunization record that includes your name, birthdate and the name of the medical practice where you received the vaccines to this health form; however, you still must submit this JHU SHWC pre-entrance health form.

Required Immunizations (A-E):

A-D. Measles, Mumps and Rubella (MMR) Vaccine: Two doses of MMR Vaccine OR two doses each of measles and mumps vaccine PLUS one dose of rubella vaccine. All doses must be administered at 12 months of age or older and at least 28 days apart. If you are unsure of the dates of your vaccinations and you do not wish to be revaccinated, you can provide proof of immunity by submitting the antibody blood titer test results indicating immunity.

	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 within the last 10 years. Td (Tetanus-diphtheria) does not satisfy this requirement. Do not confuse the adult Tdap with the DTaP vaccine given before age 7.

Date of Tdap:	____/____/____ Mo. Day Year

Recommended Immunizations (F-K):

F. Varicella (chicken pox): 2 doses of varicella vaccine received at least one month apart 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. **Type:** ☐OPV ☐IPV ☐Unknown				
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. Human Papillomavirus (HPV) recommended for females/males up to age 26 *(3 dose series)*	**Dose 1** _____/_____/_____ Mo. Day Yr.	**Dose 2** _____/_____/_____ Mo. Day Yr.	**Dose 3** _____/_____/_____ Mo. Day Yr.	

Tuberculosis Risk Assessment

Not all students require screening for tuberculosis. To avoid unnecessary and potentially costly testing, please review this information carefully.

I. Have you ever spent four consecutive weeks or longer in any of the following **areas with a high incidence of tuberculosis** as defined by the World Health Organization?

- **Africa**- All countries except Egypt
- **Asia/South Asia/Southeast Asia/Pacific Islands-**All countries except Tonga and Samoa.
- **North, Central & South America-**Argentina, Belize, Bolivia, Brazil, Colombia, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, St. Vincent & the Grenadines, Suriname, Trinidad and Tobago, Uruguay, Venezuela
- **Europe-** Armenia ,Belarus, Bosnia-Herzegonia, Bulgaria, Estonia, Latvia, Lithuania, Moldova, Poland, Portugal, Romania, Russian Federation, Serbia, Ukraine, Yugoslavia
- **Middle East**- Afghanistan, Azerbaijan, Bahrain, Bangladesh, Bhutan, Iran, Iraq, Kazakhstan, Kuwait, Kyrgyzstan, Pakistan, Qatar, Tajikistan, Turkey, Turkmenistan, Uzbekistan, Yemen

An alphabetical list of high prevalence countries can also be found on our website.

☐ No.→ You can skip to page 4.

☐ Yes.→ TB screening is required within the 6 month period prior to your arrival on campus.

Have you ever received the BCG vaccine?

☐ No. →Either skin (PPD) or blood test is acceptable OR you can submit chest x-ray results (see C below).

☐ Yes.→ Blood testing for tuberculosis is preferred OR you can submit chest x-ray results (see C below).

II. Type of test

A. Tuberculin skin test (PPD). If you have previously had a positive PPD/Mantoux skin test, do not repeat the skin test; a chest x-ray is required (part C below).

Date given	Date Read	Result	Interpretation(circle one)
____/_____/_____ Mo. Day Year	____/_____/_____ Mo. Day Year	_____ **mm induration**	positive/negative (if positive, chest x-ray is required)

B. **Blood test** (preferred if you have received the BCG vaccine)

Date of test	Type of test administered	Result(circle one)
____/_____/_____ Mo. Day Year	☐ **QuantiFERON®-TB Gold** ☐ **T-SPOT ®**	positive/negative (if positive, chest x-ray is required)

C. **If PPD is equal to or greater than 10mm induration or your blood test is positive, a chest x-ray is required.** The x-ray must be obtained no more than 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**

D. If you screened positive for TB, did you receive Isoniazid (INH) therapy? ☐ No ☐ Yes→ provide dates below.

INH Start Date	INH Stop date
____/____/____ 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**.
In lieu of a physician's signature, you may attach a copy of your official immunization record.

Provider Name:_____ Date: _____

Address:_____ Telephone: _____

Signature/Stamp : _____

Consent to Medical and/or Surgical Procedure

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 Physical Education 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.

Signature:_____ Date: _____

Parent Signature (if under 18 years of age):_____ Date: _____