JOHNS HOPKINS UNIVERSITY | Student Health & Well-Being

Student Name: _____ _____
(Last or Family Name) (First or Given Name)

Date of Birth: _____ /____ /_____
Month / Day / Year

# Pre-Entrance Health Form for Non-Clinical Students

## INSTRUCTIONS:

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

DUE: Please refer to our website for submission and compliance deadlines

- ☐ Have your provider complete this form OR obtain a copy of your official vaccine records in English
- ☐ Go to the MyHealth portal, upload this form signed by a medical provider OR official vaccine records to "REQUIRED FORMS & IMMUNIZATIONS" (accepted upload formats in Portrait orientation are gif, jpg, png, or pdf)
- ☐ Enter immunization dates for each vaccine or test result
- ☐ Complete "consent to treatment" form - if under 18, a parent or guardian needs to complete and submit the "Consent for Treatment of Minor" form
- ☐ Complete TB Risk Assessment, please note you may be required to do additional tests and provide information depending on the assessment

## REQUIRED IMMUNIZATIONS:

| | | | | |
|---|---|---|---|---|
| **MMR (Measles, Mumps, Rubella):** *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: _____ Month/Day/Year | Dose 2: _____ Month/Day/Year |
| **Measles,** *if given individually OR date and result of immune titer* | Dose 1: _____ Month/Day/Year | Dose 2: _____ Month/Day/Year | Titer Date: _____ Month/Day/Year | Titer Result: ☐ Immune ☐ Non-Immune |
| **Mumps,** *if given individually OR date and result of immune titer* | Dose 1: _____ Month/Day/Year | Dose 2: _____ Month/Day/Year | Titer Date: _____ Month/Day/Year | Titer Result: ☐ Immune ☐ Non-Immune |
| **Rubella,** *if given individually OR date and result of immune titer* | Dose 1: _____ Month/Day/Year | Dose 2: _____ Month/Day/Year | Titer Date: _____ Month/Day/Year | Titer Result: ☐ Immune ☐ Non-Immune |
| **Tdap (tetanus, diphtheria, and pertussis)**: *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.* | | | | _____ Month/Day/Year |
| **Varicella (chicken pox):** *2 doses of varicella OR provide titer OR approximate date of disease.* | Dose 1: _____ Month/Day/Year | Dose 2: _____ Month/Day/Year | Titer Date: _____ Month/Day/Year | Titer Result: ☐ Immune ☐ Non-Immune |
| OR approximate date of chicken pox disease: | | | | _____ Month//Year |
| **Meningococcal Vaccine:** *Under Maryland law, students who reside in on-campus housing 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 in the health portal under REQUEST EXEMPTION located in our REQUIRED FORMS & IMMUNIZATIONS SECTION.* | | | _____ Month/Day/Year | Type of Vaccine Given: ☐ Menactra ☐ Menveo ☐ Other: _____ |
| **COVID-19 School of Medicine (SOM) only:** *Must have received the complete primary series or a booster dose of any FDA- or WHO- authorized vaccine.* | Dates of FDA- or WHO-authorized vaccine: _____ Month/Day/Year | | Vaccine Manufacturer: _____ | |

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| | | | | | |
|---|---|---|---|---|---|
| **Annual Flu Vaccine:** *Seasonal Vaccine for Influenza - August 1st through May 15th of each year. Johns Hopkins University requires the flu vaccine from the current flu season for all students. Only if you have received the current season's flu vaccine, given AFTER AUGUST 1st write a date. Otherwise, please leave it blank.* | | | | | Date of Current Season's Flu Vaccine: _____ Month/Day/Year |
| **Tuberculosis Risk Assessment:** *To be completed in the health portal. Available in the "required forms and immunization section." Per the assessment if you are cleared no further steps are required.* | | | | | |
| *If you are NOT CLEARED, you are required to provide the following information:* | | | | | |
| *We only accept TB screening via IGRA blood test. Test must be completed within 12 months prior to your arrival on campus. If the result is indeterminate, repeat the test for conclusive result. Please provide a copy of the lab report in English.* | | | IGRA Test Date: _____ Month/Day/Year | Test Result: ☐ Positive ☐ Negative | Type of Test Administered: ☐QuantiFERON ®-TB Gold ☐ T-SPOT ® |
| *IF YOU HAVE a POSITIVE blood test, a chest x-ray is required within 12 months prior to your arrival on campus. If abnormal, upload a copy of chest x-ray report in English.* | | | | Chest XR Date: _____ Month/Day/Year | Result: ☐ Normal ☐ Abnormal |
| *If you screened positive for TB, have you received treatment for latent TB?* | ☐ Yes ☐ No | If yes → | Name of Medication(s): _____ | Start Date: _____ Month/Day/Year | Stop Date: _____ Month/Day/Year |

**RECOMMENDED IMMUNIZATIONS:**

| | | | | |
|---|---|---|---|---|
| **HPV (Human Papillomavirus):** | | Dose 1: _____ Month/Day/Year | Dose 2: _____ Month/Day/Year | Dose 3: _____ Month/Day/Year |
| **Group B Meningitis:** | Dose 1: _____ Month/Day/Year | Dose 2: _____ Month/Day/Year | Dose 3: _____ Month/Day/Year | Type of Vaccine Given: ☐ Bexsero ☐ Trumenba |
| **Polio:** | Completed primary series? ☐ Yes ☐ No | | Date of Last Dose: _____ Month/Day/Year | |
| **Hepatitis B:** | Dose 1: _____ Month/Day/Year | Dose 2: _____ Month/Day/Year | Dose 3: _____ Month/Day/Year | Type of Vaccine Given: ☐ Engerix-B ☐ Heplisav-B ☐ Other: |
| **Hepatitis A:** | | | Dose 1: _____ Month/Day/Year | Dose 2: _____ Month/Day/Year |
| **Td booster (Tetanus-diphtheria):** *ONLY add a date here if you received a Tdap and have subsequently received a Td booster* | | | | _____ Month/Day/Year |

Healthcare provider signature/stamp OR, in lieu of health care provider signature/stamp, upload official VACCINE RECORDS to the health portal. In following the AMA Code of Medical Ethics, the JHU SHWB will not accept any medical forms completed by a medical clinician family member.

**Health Care Provider Information:** I have reviewed all the information on this form and certify that it is complete and accurate.

**Provider Name: _____Date: _____**
**Provider Signature/Stamp: _____**
**Address: _____ Telephone: _____**