Henry Wise Wellness Center

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**Mandatory Entrance Medical History Form**

*PLEASE COMPLETE THIS FORM AND SUBMIT BY US MAIL, FAX, DROPOFF OR UPLOAD*

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| **SECTION A- PERSONAL INFORMATION (REQUIRED)** *Print Legibly*  Name (Last): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (First) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Middle) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Student ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Admit Term (circle one): Spring or Fall; Year\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_  Student Status: \_\_\_In State \_\_\_Out of State \_\_\_International Student Housing: Do you plan to live on campus (circle one): Yes No  Gender (circle one): Male Female Transgender: Male → Female or Female→ Male  Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Emergency Contact Name & Number : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Contact Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **SECTION B: MEASLES, MUMPS, RUBELLA (MMR)- ALL STUDENTS MUST COMPLETE THIS SECTION (REQUIRED)** *Print Legibly*  First dose must be given after 1st birthday. MMR can be waived if you were born in or before 1956  MMR #1\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ MMR #2 \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_  mm dd yyyy mm dd yyyy  OR  Rubeola (Measles) Titer \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ Result (circle one): Immune / Not Immune / Equivocal  mm dd yyyy |
| **SECTION C: MENINGITIS** (**A, C, W, Y)- REQUIRED FOR ALL STUDENTS WHO PLAN TO LIVE ON CAMPUS** *Print Legibly*  Students who plan to apply for on-campus housing. One dose must be given on or after 16 years of age. If not, please sign the Meningitis Vaccine Waiver (Section F).  Meningitis ACWY \_\_\_\_\_\_/\_\_\_\_\_\_/ \_\_\_\_\_\_\_\_ Vaccine Name (circle one): Menactra / Menveo / Unknown  mm dd yyyy |
| **SECTION D: TUBERCULOSIS SCREENING- REQUIRED FOR INTERNATIONAL STUDENTS** *Print Legibly*  Test must be performed within the past 12 months.  Blood Test (circle one): QuantiFERON-TB Gold / T-Spot \_\_\_\_/ \_\_\_\_/ \_\_\_\_\_\_ Result (circle one): Positive / Negative  mm dd yyyy  \*Tuberculin Skin Test is no longer accepted |
| **SECTION E: Recommended Vaccines ( OPTIONAL FOR ALL STUDENTS)** *Print Legibly*  Tdap ( within 10 years) \_\_\_\_/ \_\_\_\_/ \_\_\_\_\_\_ OR Td \_\_\_\_/ \_\_\_\_/ \_\_\_\_\_\_  mm dd yyyy mm dd yyyy  Meningitis B \_\_\_\_/ \_\_\_\_/ \_\_\_\_\_\_ \_\_\_\_/ \_\_\_\_/ \_\_\_\_\_\_ \_\_\_\_/ \_\_\_\_/ \_\_\_\_\_\_  mm dd yyyy mm dd yyyy mm dd yyyy Vaccine Name (circle one): Bexsero / Trumenba |

Signature of Health Care Provider Print Name Phone Number Date

**Acceptable documentation in lieu of health care provider signature (Must be in English): School or university immunization record, Immunization record from your health care provider’s office with contact information and / or Military immunization form (DD214)**

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| **Section F. Meningitis Vaccine Acknowledgement**  A Meningococcal Vaccine is available for protection against most strains of the bacteria that causes meningitis. Meningitis is inflammation of the covering o the brain and spinal cord that is fatal in 10-15% of cases. Although the disease is rare, college students living in dormitories and individuals with weak immune systems can be more susceptible to the disease. The immunization requires one injection in the arm and is 85-90% protective against strains A, C, Y, and W-135, but not type B. Most meningococcal diseases in the U.S. are causes by type B or C.  **I understand that under Maryland law, students enrolled in a Maryland institution of higher education residing in on-campus student housing are required to be vaccinated against the meningococcal meningitis disease or may seek exemption from this law.** I have read the meningitis material where the risks are detailed. In addition, I acknowledge the detrimental health effects of the disease. Lastly, I have read and understand the availability and effectiveness of the vaccine, which is available from the Bowie State University Student Health Center or from my personal health care provider**. I will make every attempt to have the meningitis vaccine administered by September 30, 2020 in order to abide with Maryland State Law and to reduce my risk of acquiring the Meningitis infection.**  **\_\_\_** I have read about the Meningococcal Disease. I have read and understand the benefits of the vaccine for Meningococcal Meningitis. I **do not wish** to receive the vaccine and I voluntarily agree to release, discharge, indemnify, and hold harmless the State of Maryland, the University, its officers, employees, and agents from any and all costs, liabilities, expenses, claims, demands, or causes of action on account of loss or personal injury that might result from my non-compliance with the law.  Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_/ \_\_\_\_\_/ \_\_\_\_\_  (Parent or guardian must sign for student under 18) mm dd yyyy |
| **SECTION G: SIGNATURE (Required): ALL students or parents / guardians must sign the form below:**  Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  mm dd yyyy  **Parental Permit (for students under 18 on the first day of admission to BSU)**  I give my permission for such diagnosis and therapeutic procedures as may be deemed necessary for my child and agree to present information concerning their medical condition to other responsible officials when deemed necessary.  Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_/ \_\_\_\_\_/ \_\_\_\_\_  mm dd yyyy  Relationship to student \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**PLEASE NOTE:**

* **You may upload your document through wellness center patient portal, please visit https://patientportal.bowiestate.edu/login\_directory.aspx**
* **It is recommended that all students have personal health insurance.**
* **Incomplete forms will NOT be processed and will result in registration blocks.**
* **If you are submitting supporting documents, please submit a copy of your files instead of your original files.**

For Staff Use Only:

Student ID Number: ­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Received: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

mm dd yyyy

□MMR □MEN. □ MEN. WAIVER □TB

□Complete □Incomplete

□Contacted; Date \_\_\_\_\_\_\_\_\_\_\_\_

Staff Initials \_\_\_\_\_\_

Comments: