JOHNS HOPKINS UNIVERSITY | Student Health & Well-Being

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 date of birth, 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 - **Blocked from utilizing the SHWC services.**

DUE: Prior to appointment start date

Part 1: General Information (REQUIRED)

Name: _____ _____ _____ **Date of Birth:** ____/____/____
(Last or Family Name) (First or Given Name) (Middle Name) 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 ☐ Other **Appointment period**: ____/____/____ through: ____/____/____
MM/DD/YYYY 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-E):

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

Non-required Immunizations (F-L):

F. **Human Papillomavirus (HPV)**	**Dose 1** ____/____/____ Mo. Day Yr.	**Dose 2** ____/____/____ Mo. Day Yr.	**Dose 3** ____/____/____ Mo. Day Yr.	
G. **Group B Meningitis** ☐ **Be**xsero ☐ Trumenba	**Dose 1** ____/____/____ Mo. Day Yr.	**Dose 2** ____/____/____ Mo. Day Yr.	**Dose 3** ____/____/____ Mo. Day Yr.	
H. **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.
I. **Polio:** Completed primary series: ☐ **Y**es ☐ No **Date of last dose**: ____/____/____ Mo. Day Yr.				
J. **Hepatitis B** *(3 dose series)*	**Dose 1** ____/____/____ Mo. Day Yr.	**Dose 2** ____/____/____ Mo. Day Yr.	**Dose 3** ____/____/____ Mo. Day Yr.	
K. **Hepatitis A** *(2 dose series)*	**Dose 1** ____/____/____ Mo. Day Yr.	**Dose 2** ____/____/____ Mo. Day Yr.		
L. **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.			

University Requirement

PLEASE upload your COVID vaccines and Flu Vaccine documentation to JHU VMS:
Vaccine Management System | Coronavirus Information (jhu.edu).

Flu vaccine is only for current season, August 2023 through May 2024.

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	Central African Republic	Ghana	Madagascar	Palau	Tajikistan
Algeria	Chad	Guam	Malawi	Panama	Thailand
Angola	China	Guatemala	Malaysia	Papua New Guinea	Timor-Leste
Anguilla	China, Hong Kong SAR	Guinea	Maldives	Paraguay	Togo
Argentina	China, Macao SAR	Guinea-Bissau	Mali	Peru	Tunisia
Armenia	Colombia	Guyana	Marshall Islands	Philippines	Turkmenistan
Azerbaijan	Comoros	Haiti	Mauritania	Qatar	Tuvalu
Bangladesh	Congo	Honduras	Mexico	Republic of Moldova	Uganda
Belarus	Côte d'Ivoire	India	Micronesia	Romania	Ukraine
Belize	Democratic Republic of the Congo	Indonesia	Mongolia	Russian Federation	United Republic of Tanzania
Benin	Djibouti	Iraq	Morocco	Rwanda	Uruguay
Bhutan	Dominican Republic	Kazakhstan	Mozambique	Sao Tome & Principe	Uzbekistan

Bolivia	Ecuador	Kenya	Myanmar	Senegal	Vanuatu
Bosnia & Herzegovina	El Salvador	Kiribati	Namibia	Sierra Leone	Venezuela
Botswana	Equatorial Guinea	Korea, North & South	Nauru	Singapore	Viet Nam
Brazil	Eritrea	Kuwait	Nepal	Solomon Islands	Yemen
Brunei Darussalam	Eswatini	Kyrgyzstan	Nicaragua	Somalia	Zambia
Burkina Faso	Ethiopia	Lao People's Democratic Republic	Niger	South Africa	Zimbabwe
Burundi	Fiji	Lesotho	Nigeria	South Sudan	
Cabo Verde	Gabon	Liberia	Niue	Sri Lanka	
Cambodia	Gambia	Libya	Northern Mariana Islands	Sudan	
Cameroon	Georgia	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 test (we **only** accept the IGRA blood test)

A. IGRA 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.