JOHNS HOPKINS UNIVERSITY | Student Health & Well-Being

Pre-Entrance Health Form
(AS/EN/PY/SOE/Carey)

☐**Step 1**. Complete this form as indicated. **Save to your desktop as PDF or JPG.**
☐**Step 2**. Attach this saved form (signed by medical provider or with attached vaccine history records) and send to healthforms@jhu.edu for review. If you are missing requirements you will receive an email from us.
☐**Step 3**. Log into MyHealth Portal to complete 'assessments & surveys' on left side of home screen.

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: _____ (Last or Family Name) _____ (First or Given Name) _____ (Middle Name) **Date of Birth**: ____/____/_____ Month Day Year

Hopkins ID (6 characters; found in SIS): _____ **Email Address** (JHU preferred): _____

Home Phone (USA): _____ Including Area Code **Student US Cell Phone**: _____ 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 _____ ☐ Carey Business/Harbor East ☐ Education ☐ Peabody ☐ Homewood UG Transfer ☐ Exchange

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-F):

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:** _____

Non-Required Immunizations (G-M):

G. Human Papillomavirus (HPV)	**Dose 1** ____/____/____ Mo. Day Yr.	**Dose 2** ____/____/____ Mo. Day Yr.	**Dose 3** ____/____/____ Mo. Day Yr.		
H. Group B Meningitis ☐Bexsero ☐ Trumenba	**Dose 1** ____/____/____ Mo. Day Yr.	**Dose 2** ____/____/____ Mo. Day Yr.	**Dose 3** ____/____/____ Mo. Day Yr.		
I. 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.	
J. Polio: Completed primary series: ☐Yes ☐ No **Date of last dose**: ____/____/____ Mo. Day Yr.					
K. Hepatitis B *(3 dose series)*	**Dose 1** ____/____/____ Mo. Day Yr.	**Dose 2** ____/____/____ Mo. Day Yr.	**Dose 3** ____/____/____ Mo. Day Yr.		
L. Hepatitis A *(2 dose series)*	**Dose 1** ____/____/____ Mo. Day Yr.	**Dose 2** ____/____/____ Mo. Day Yr.	[redacted]		
M. 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 IGRA blood test is required.**

Type of blood test (we **only** accept the blood test)

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

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.
____/_____/_____ Mo. Day Year	____/_____/_____ Mo. Day Year	☐Normal ☐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.