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 possible orientation interruption & you will be blocked from adding or dropping classes. **A $100 fee will be charged for completion at a Student Health Clinic.**

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, given after first birthday and at least 28 days apart OR provide titer OR approximate date of disease supported by proper medical documentation*	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 with appropriate documentation:				_____ 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: SOM ONLY *Must have received at least one dose of any FDA- or WHO-authorized vaccine.*	Date of most recent 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 complete Option A **OR** B:*					
Option A (No Prior Positive TB Blood Test)					
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. **TB Skin Test/PPD is not accepted			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. Upload a copy of chest x-ray report in English.*				Chest XR Date: _____ Month/Day/Year	Result: ☐ Normal ☐ Abnormal
Option B (Prior history of positive TB Blood Test)					
*If you have tested positive for TB in the past, provide historical test results **(No need to repeat the IGRA Blood Test**. TB Skin Test/PPD is not accepted)*				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. Upload a copy of chest x-ray report in English.*				Chest XR Date: _____ Month/Day/Year	Result: ☐ Normal ☐ Abnormal
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

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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: _____