A complete Health History Form, recorded in English, documenting that all medical history, physical, and immunization requirements are met, must be completed prior to entry into all programs of study. Failure to complete this form and comply with immunization requirements by the first day of classes will result in a late fee. Failure to complete all requirements by the 30th day of classes may result in withdrawal.

## PART ONE: STUDENT IDENTIFICATION – to be completed by student

<table>
<thead>
<tr>
<th>NAME - LAST</th>
<th>FIRST</th>
<th>MI</th>
<th>UR STUDENT ID#</th>
<th>DATE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>DATE OF BIRTH (mo/day/yr)</th>
<th>COUNTRY OF RESIDENCE WITHIN PAST 5 YEARS</th>
<th>GENDER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ USA ☐ Other (specify):</td>
<td>☐ Male</td>
</tr>
</tbody>
</table>

HOME ADDRESS

<table>
<thead>
<tr>
<th>CITY</th>
<th>STATE</th>
<th>ZIP</th>
<th>(AREA CODE) PHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cell:______________</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Other:____________</td>
</tr>
</tbody>
</table>

SCHOOL OR COLLEGE REGISTRATION INFORMATION

- ☐ School of Medicine & Dentistry (MD students)  Expected year of graduation: __________
- ☐ Eastman Institute of Oral Health
- ☐ School of Nursing
  - ☐ Accelerated Nursing Program
  - ☐ RN Matriculated
  - ☐ Masters
  - ☐ Post Masters Certificate Program
  - ☐ PhD
  - ☐ DNP

ENTERING SEMESTER

- ☐ Fall ☐ 2017
- ☐ Spring ☐ 2018
- ☐ Summer ☐ 2019

STUDENT STATUS

- ☐ Full-time
- ☐ Part-time*  *Note: Part-time students are required to submit a $35 processing fee with this form. Enclose a personal check payable to UHS or your term bill will be charged directly.

Previous UR student: ☐ Yes
Previous UR Employee/Volunteer: ☐ Yes

## PART TWO: PERSONAL HEALTH HISTORY - This information is strictly for the use of the University of Rochester and will not be released to anyone without your knowledge and written consent.

Do you take daily medication? ☐ Yes ☐ No
Do you have any medication/substance allergies? ☐ Yes ☐ No

Latex allergy? ☐ Yes ☐ No  Describe: ________________________________
Take allergy desensitization injections? ☐ Yes ☐ No  If yes, do you plan to receive your allergy injections at UHS? ☐ Yes ☐ No
### MEDICAL OR HEALTH CONCERNS – Please mark any conditions/diseases you have had.

<table>
<thead>
<tr>
<th>Dizziness/fainting</th>
<th>Dizziness/fainting</th>
<th>Dizziness/fainting</th>
<th>Dizziness/fainting</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADD/ADHD</td>
<td>Hypertension</td>
<td>Hypertension</td>
<td>Hypertension</td>
</tr>
<tr>
<td>Anemia</td>
<td>Migraine/recurrent</td>
<td>Migraine/recurrent</td>
<td>Migraine/recurrent</td>
</tr>
<tr>
<td>Asthma</td>
<td>Recurrent headache</td>
<td>Recurrent headache</td>
<td>Recurrent headache</td>
</tr>
<tr>
<td>Arthritis</td>
<td>Headache</td>
<td>Headache</td>
<td>Headache</td>
</tr>
<tr>
<td>Anxiety or nervousness</td>
<td>Heart disease</td>
<td>Heart disease</td>
<td>Heart disease</td>
</tr>
<tr>
<td>Bleeding disorder</td>
<td>High blood pressure</td>
<td>High blood pressure</td>
<td>High blood pressure</td>
</tr>
<tr>
<td>Blood disorder</td>
<td>High cholesterol</td>
<td>High cholesterol</td>
<td>High cholesterol</td>
</tr>
<tr>
<td>Cancer/malignancy</td>
<td>Inflammatory bowel disease/</td>
<td>Inflammatory bowel disease/</td>
<td>Inflammatory bowel disease/</td>
</tr>
<tr>
<td>Cerebral palsy</td>
<td>Crohn's, ulcerative colitis</td>
<td>Crohn's, ulcerative colitis</td>
<td>Crohn's, ulcerative colitis</td>
</tr>
<tr>
<td>Chicken pox</td>
<td>Insomnia</td>
<td>Insomnia</td>
<td>Insomnia</td>
</tr>
<tr>
<td>Cystic Fibrosis</td>
<td>Kidney problems</td>
<td>Kidney problems</td>
<td>Kidney problems</td>
</tr>
<tr>
<td>Depression</td>
<td>Menstrual problems</td>
<td>Menstrual problems</td>
<td>Menstrual problems</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Digestive troubles</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do you have an illness, chronic condition or medical problem for which you are currently being treated?  [ ] Yes  [ ] No

Describe: __________________________________________________________________________________________________

Have you had any hospitalizations or surgeries?  [ ] Yes  [ ] No

If yes, list date(s) and reason(s) ________________________________________________________________________________

Do you regularly exercise, 3 or more times per week?  [ ] Yes  [ ] No

Do you currently smoke or chew tobacco?  [ ] Yes  [ ] No  If Yes, how much? _____________________________________________

Do you drink alcohol?  [ ] Yes  [ ] No  If Yes, how much and how often____________________________________________________

Have you used any drugs such as marijuana, cocaine, heroin or crack within the last year?  [ ] Yes  [ ] No

If Yes, describe: ________________________________________________________________________________________________

Do you have any treatment for drug or alcohol abuse?  [ ] Yes  [ ] No

If yes, describe (including year): ________________________________________________________________________________

Do you have any health impairments (including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter behavior) that would pose a potential risk to patients or personnel, or which might interfere with the performance of your responsibilities?  [ ] Yes  [ ] No

If yes, explain: ________________________________________________________________________________________________

### PART THREE: FAMILY MEDICAL HISTORY

Mark all the diseases that apply to your family:

- Heart disease
- Hypertension
- Diabetes
- Cancer
- Emotional / mental illness
- Alcohol/drug addiction
- Stroke
- Other (please specify):

### PART FOUR: CERTIFICATION

I certify that the information submitted on this form is accurate to the best of my knowledge. I will contact University Health Service if I have any further questions about these issues.

STUDENT NAME (please print): ___________________________________________ DATE: __________________

STUDENT SIGNATURE: ________________________________________________
## Part Five: The Requirements Below Need Health Care Provider Verification

### Federal, New York State & University Requirements

#### MMR Documentation

- **1st Immunization:** mm/dd/yy
- **2nd Immunization:** mm/dd/yy

#### Measles Documentation

- **1st Immunization:** mm/dd/yy AND **2nd Immunization:** mm/dd/yy
- **Serologic Test:** mm/dd/yy
- **Result:**
  - positive
  - indeterminate
  - negative

#### Mumps Documentation

- **1st Immunization:** mm/dd/yy AND **2nd Immunization:** mm/dd/yy
- **Serologic Test:** mm/dd/yy
- **Result:**
  - positive
  - indeterminate
  - negative

#### Rubella Documentation

- **Immunization:** mm/dd/yy
- **Serologic Test:** mm/dd/yy
- **Result:**
  - positive
  - indeterminate
  - negative

### Tuberculin Skin Test (Mantoux) Requirements

- **Two TST’s (Mantoux intradermal skin tests)**: The 1st is due within one year of the start date of the program and the 2nd is due within 3 months of that start date. Time tests or history of BCG do not meet the requirement. If positive TST or history of past positive TST is reported, a chest x-ray must be obtained after positive TST and a copy of the chest x-ray report attached. Example: Start Date (9/1/12)
  - 1st TST (9/1/11 to 8/31/12)
  - 2nd TST (6/1/12 to 8/31/12)

#### Manufacturer: _____

- **#1 Date Placed:** mm/dd/yy
- **Date Read:** mm/dd/yy
- **mm of induration:** ____________
  - Interpretation:
    - positive
    - negative

#### Manufacturer: _____

- **#2 Date Placed:** mm/dd/yy
- **Date Read:** mm/dd/yy
- **mm of induration:** ____________
  - Interpretation:
    - positive
    - negative

### Tetanus- Diphtheria or Tdap

- **Immunization:** mm/dd/yy
- **Td** ☐ **Tdap** ☐

#### Tetanus-Diphtheria (every 10 years)

- **OR Tdap:** The CDC recommends that health providers who have direct patient contact should receive a single dose of Tdap as soon as feasible if they have not previously received it. Reference: 12/06 http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5517a2.htm

### Polio Vaccine

- **IPV** ☐ **OPV** ☐

#### Immunization mm/dd/yy (date of completion)
IMMUNIZATIONS AND TESTS: INFORMATION IS REQUIRED

**Hepatitis B vaccine**: The CDC STRONGLY RECOMMENDS hepatitis B vaccination (includes 3 doses of vaccine and post-vaccine titer 1-2 months after 3rd dose) for all health care professionals. A signed declination form must be completed if this applicant declines vaccine.

**Varicella Status**: Documentation of 2 doses of varicella vaccine or a varicella titer result must be provided. UHS strongly recommends vaccination for any students who have a negative varicella titer.

**Meningococcus Vaccine**: Review enclosed information

### HEPATITIS B

<table>
<thead>
<tr>
<th>Immunization #1</th>
<th>mm/dd/yy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunization #2</td>
<td>mm/dd/yy</td>
</tr>
<tr>
<td>Immunization #3</td>
<td>mm/dd/yy</td>
</tr>
</tbody>
</table>

Serologic Test:________________ Result: ______________

(If available) mm/dd/yy (include copy of lab report if available)

☐ DECLINATION: I decline the hepatitis B Vaccination at this time.

I understand that by declining this vaccine, I continue to be at risk for acquiring hepatitis B. I understand the risks of being susceptible to infections and blood borne diseases and decline immunization at this time. I understand I may choose to receive the vaccine at any time in the future.

Declination Signature of Student: ___________________________ Date__________

### MENINGOCOCCUS VACCINE:

<table>
<thead>
<tr>
<th>Immunization #1</th>
<th>mm/dd/yy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunization #2</td>
<td>mm/dd/yy</td>
</tr>
</tbody>
</table>

☐ DECLINATION: I certify that I have received the information about the risks, benefits, availability and alternatives to meningococcus vaccination. I understand the information and I decline the meningococcus vaccination at this time. I understand that by declining this vaccine, I continue to be at risk for acquiring meningitis. I understand I may choose to receive the vaccine at any time in the future.

Declination Signature of Student: ___________________________ Date__________

### VARICELLA (CHICKEN POX)

Serologic Test:________________ Result: __________________

mm/dd/yy (lab report must be included)

OR

<table>
<thead>
<tr>
<th>Immunization #1</th>
<th>mm/dd/yy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunization #2</td>
<td>mm/dd/yy</td>
</tr>
</tbody>
</table>

### Optional:

**HUMAN PAPILLOMA VIRUS VACCINE (HPV):**

<table>
<thead>
<tr>
<th>Immunization #1</th>
<th>mm/dd/yy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunization #2</td>
<td>mm/dd/yy</td>
</tr>
<tr>
<td>Immunization #3</td>
<td>mm/dd/yy</td>
</tr>
</tbody>
</table>

### PART SIX: TO BE COMPLETED IN INK BY HEALTH CARE PRACTITIONER.

Physical exam form provided to be submitted with this form.

I have reviewed all of the above information including immunization dates and it is correct to the best of my knowledge.

Practitioner’s Name (please print): __________________________________________________________

Practitioner’s Signature: ________________________________________________________________

Address: _______________________________________________________________________________

City                                State           Zip Code                         Country

Work Telephone (         )____________________________                             Date of completion of form _______/_______/_______