**UNIVERSITY OF ROCHESTER**
**HEALTH HISTORY AND IMMUNIZATION REPORT**

# HEALTH PROFESSION STUDENTS

**MAIL FORM TO:**

**University Health Service**
**PO Box 270617**
**Rochester, NY 14627-0617**

Phone: (585) 275-4955
Fax: (585) 461-9636

**A complete Health History Form, recorded in English, doumenting that all medical history, physical, and immunization requirements are met, must be complieted prior to entry in to 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*

| NAME - LAST | FIRST | MI | UR STUDENT ID# | DATE |
|---|---|---|---|---|
| | | | | |

| DATE OF BIRTH (mo/day/yr) | COUNTRY OF RESIDENCE WITHIN PAST 5 YEARS | GENDER |
|---|---|---|
| | ❒ USA ❒ Other (specify): | ❒ Male ❒ Female<br>❒ Specify_____ |

| HOME ADDRESS | EMAIL |
|---|---|
| | |

| CITY | STATE | ZIP | (AREA CODE) PHONE |
|---|---|---|---|
| | | | Cell:_____<br>Other: _____ |

**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.*

| | | | |
|---|---|---|---|
| ❒ ADD/ADHD<br>❒ Anemia<br>❒ Asthma<br>❒ Arthritis<br>❒ Anxiety or nervousness<br>❒ Bleeding disorder<br>❒ Blood disorder<br>❒ Cancer/malignancy<br>❒ Cerebral palsy<br>❒ Chicken pox<br>❒ Cystic Fibrosis<br>❒ Depression<br>❒ Diabetes mellitus<br>❒ Digestive troubles | ❒ Dizziness/fainting<br>❒ Eating disorder: anorexia nervosa, bulimia<br>❒ Hay fever/seasonal allergies<br>❒ Heart disease<br>❒ Hepatitis<br>❒ High blood pressure<br>❒ High cholesterol<br>❒ HIV/AIDS<br>❒ Inflammatory bowel disease/ Crohn's, ulcerative colitis<br>❒ Insomnia<br>❒ Kidney problems<br>❒ Menstrual problems | ❒Migraine/recurrent headache<br>❒ Multiple sclerosis<br>❒ Obesity<br>❒ Pain, chronic<br>❒ Peptic ulcer / GERD<br>❒ Pelvic infection<br>❒ Phlebitis/blood clot<br>❒ Polio<br>❒ Prostatitis<br>❒ Rheumatic fever<br>❒ Seizure disorder (epilepsy)<br>❒ Sexually transmitted infections<br>❒ Skin disorder | ❒ Systemic lupus erythematosus<br>❒ Thyroid disorder<br>❒ Past positive tuberculin skin test<br>❒ Treatment to prevent tuberculosis for positive PPD Date Treated:_____<br>❒ Treatment for active Tuberculosis Date Treated: _____<br>❒ Urinary disorders/infections<br>❒ Other (specify)<br>_____ |

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

Describe: _____

If yes, please specify and have your physician write a medical summary and enclose with this form. (Full time students)

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: _____

Have you had 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

| Instructions<br><br>MMR<br><br>Documentation | **MEASLES (RUBEOLA)**<br>▪ **2 doses of live vaccine** given on or after the first birthday: must be given at least 28 days apart with the second dose after age 15 months<br>▪ OR **serologic test** showing positive titer **(lab report must be included)**<br>▪ *May substitute MMR.* | **MUMPS**<br>▪ **2 doses of live vaccine** given on or after the first birthday: must be given at least 28 days apart with the second dose after age 15 months<br>▪ OR **serologic test** showing positive titer **(lab report must be included)**<br>▪ *May substitute MMR.* | **RUBELLA**<br>▪ **1 dose of live vaccine** given on or after the first birthday<br>▪ OR **serologic test** showing positive titer **(lab report must be included)**<br>▪ *May substitute MMR.* |
|---|---|---|---|
| **MMR Documentation**<br><br>**1st Immunization:** _____ mm/dd/yy<br><br>**AND**<br><br>**2nd Immunization:** _____ mm/dd/yy | **Measles Documentation**<br><br>**1st Immunization:** _____ mm/dd/yy<br>**AND**<br>**2nd Immunization:** _____ mm/dd/yy<br>**OR**<br>**Serologic Test:** _____ mm/dd/yy<br><br>**Result** ❒ positive ❒ indeterminate ❒ negative | **Mumps Documentation**<br><br>**1st Immunization:** _____ mm/dd/yy<br>**AND**<br>**2nd Immunization:** _____ mm/dd/yy<br>**OR**<br>**Serologic Test:** _____ mm/dd/yy<br><br>**Result** ❒ positive ❒ indeterminate ❒ negative | **Rubella Documentation**<br><br>**Immunization:** _____ mm/dd/yy<br>**OR**<br>**Serologic Test:** _____ mm/dd/yy<br><br>**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. Tine 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 8/1/12)
2nd TST (6/1/12 to 8/31/12)

| **TST #1** | **TST #2** | **PAST POSITIVE** | **CHEST X-RAY** |
|---|---|---|---|
| **Manufacturer:** _____<br><br>**#1 Date Placed:** _____ mm/dd/yy<br><br>**Date Read:** _____ mm/dd/yy<br><br>**mm of induration:** _____<br><br>**Interpretation:** ❒ positive ❒ negative | **Manufacturer:** _____<br><br>**#2 Date Placed:** _____ mm/dd/yy<br><br>**Date Read:** _____ mm/dd/yy<br><br>**mm of induration:** _____<br><br>**Interpretation:** ❒ positive ❒ negative | **Date:** _____<br><br>**mm of induration:** _____ | **Obtained** after positive TST<br><br>**Date:** _____<br><br>**Result:** _____<br><br>**A copy of official radiology report MUST be attached**<br><br>**DO NOT SEND X-RAY** |

### 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

**Immunization #1**_____
mm/dd/yy

**Immunization #2**_____
mm/dd/yy

**Immunization #3**_____
mm/dd/yy

**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**_____

### VARICELLA (CHICKEN POX)

**Serologic Test:**_____ **Result:** _____
mm/dd/yy (lab report must be included)

**OR**

**Immunization #1**_____
mm/dd/yy

**Immunization #2**_____
mm/dd/yy

### MENINGOCOCCUS VACCINE:

**Immunization #1**_____
mm/dd/yy

**Immunization #2**_____
mm/dd/yy

❒ **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**_____

### Optional:
### HUMAN PAPILLOMA VIRUS VACCINE (HPV):

**Immunization #1**_____
mm/dd/yy

**Immunization #2**_____
mm/dd/yy

**Immunization #3**_____
mm/dd/yy

## 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** _____/_____/_____