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 ❒ Specify_____

HOME ADDRESS	EMAIL

CITY	STATE	ZIP	(AREA CODE) PHONE
			Cell:_____ Other: _____

SCHOOL OR COLLEGE REGISTRATION INFORMATION

- ❒ **School of Medicine & Dentistry (MD students) Expected year of graduation: _____**
- ❒ **Eastman Institute of Oral Health**
- ❒ **Psych Interns**

- ❒ **School of Nursing**
  - ❒ **Accelerated Nursing Program**
  - ❒ **RN Matriculated**
  - ❒ **Masters**
  - ❒ **Post Masters Certificate Program**
  - ❒ **PhD**
  - ❒ **DNP**

ENTERING SEMESTER

❒ Fall ❒ 2018
❒ Spring ❒ 2019
❒ Summer ❒ 2020

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
❒ Anemia
❒ Asthma
❒ Arthritis
❒ Anxiety or nervousness
❒ Bleeding disorder
❒ Blood disorder
❒ Cancer/malignancy
❒ Cerebral palsy
❒ Chicken pox
❒ Cystic Fibrosis
❒ Depression
❒ Diabetes mellitus
❒ Digestive troubles

❒ Dizziness/fainting
❒ Eating disorder: anorexia nervosa, bulimia
❒ Hay fever/seasonal allergies
❒ Heart disease
❒ Hepatitis
❒ High blood pressure
❒ High cholesterol
❒ HIV/AIDS
❒ Inflammatory bowel disease/ Crohn's, ulcerative colitis
❒ Insomnia
❒ Kidney problems
❒ Menstrual problems

❒Migraine/recurrent headache
❒ Multiple sclerosis
❒ Obesity
❒ Pain, chronic
❒ Peptic ulcer / GERD
❒ Pelvic infection
❒ Phlebitis/blood clot
❒ Polio
❒ Prostatitis
❒ Rheumatic fever
❒ Seizure disorder (epilepsy)
❒ Sexually transmitted infections
❒ Skin disorder

❒ Systemic lupus erythematosus
❒ Thyroid disorder
❒ Past positive tuberculin skin test
❒ Treatment to prevent tuberculosis for positive PPD
Date Treated:_____
❒ Treatment for active Tuberculosis
Date Treated: _____
❒ Urinary disorders/infections
❒ Other (specify)

_____

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: _____

Name:_____ **Date of Birth (mm/dd/yy):**_____

PART FIVE: THE REQUIREMENTS BELOW NEED HEALTH CARE PROVIDER VERIFICATION:

FEDERAL, NEW YORK STATE & UNIVERSITY REQUIREMENTS

Instructions MMR Documentation	**MEASLES (RUBEOLA)** ▪ **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 ▪ OR **serologic test** showing positive titer **(lab report must be included)** ▪ *May substitute MMR.*	**MUMPS** ▪ **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 ▪ OR **serologic test** showing positive titer **(lab report must be included)** ▪ *May substitute MMR.*	**RUBELLA** ▪ **1 dose of live vaccine** given on or after the first birthday ▪ OR **serologic test** showing positive titer **(lab report must be included)** ▪ *May substitute MMR.*
MMR Documentation **1st Immunization:**_____ mm/dd/yy **AND** **2nd Immunization:**_____ mm/dd/yy	**Measles Documentation** **1st Immunization:** _____ mm/dd/yy **AND** **2nd Immunization:** _____ mm/dd/yy **OR** **Serologic Test:**_____ mm/dd/yy **Result** ❒ positive ❒ indeterminate ❒ negative	**Mumps Documentation** **1st Immunization:** _____ mm/dd/yy **AND** **2nd Immunization:** _____ mm/dd/yy **OR** **Serologic Test:**_____ mm/dd/yy **Result** ❒ positive ❒ indeterminate ❒ negative	**Rubella Documentation** **Immunization:** _____ mm/dd/yy **OR** **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. 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:_____ **#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	**Date:**_____ **mm of induration:**_____	**Obtained** after positive TST **Date:**_____ **Result:**_____ **A copy of official radiology report MUST be attached** **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)

(Titers and antibody levels are not accepted)

Name:_____ **Date of Birth (mm/dd/yy):**_____

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**_____

MENINGOCOCCUS A VACCINE:

Immunization #1_____ ❒ Menomune ❒ Menectra
mm/dd/yy

Immunization #2_____ ❒ Menomune ❒ Menectra
mm/dd/yy

MENINGOCOCCUS B VACCINE:

Immunization #1_____ ❒ Trumenba ❒ Bexsero
mm/dd/yy

Immunization #2_____ ❒ Trumenba ❒ Bexsero
mm/dd/yy

❒ **DECLINATION:** I certify that I have received information about the risks, benefits, availability and alternatives to meningococcus vaccination. I understand the information and have either received the vaccine as recommended or choose not to do so.

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

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** _____/_____/_____