

IV. SCREENING TESTS - To be completed by Health Care Provider

A. HEIGHT, WEIGHT, BLOOD PRESSURE

Is student currently being treated for high blood pressure? YES/NO (*circle one*)

Blood Pressure: _____ / _____ Height: _____ Weight: _____

B. MENINGOCOCCAL VACCINE/WAIVER - REQUIRED

Maryland State law requires students living in University housing receive meningococcal vaccine or sign a waiver. Please indicate the date of the vaccine OR sign and date the waiver statement.

- I have received the meningococcal vaccine. I choose to decline meningococcal vaccine.

_____ Date: _____
(Specify name of vaccine)

_____ Date: _____
(Student's signature or signature of Parent/Legal Guardian for minors)

C. MMR (MEASLES, MUMPS, RUBELLA) - REQUIRED

(Two doses of MMR required or 2 Measles, 2 Mumps, and 1 Rubella as noted in i, ii, & iii)

Immunized with live vaccine at 12 months after birth or later.

Dose #1: _____
(Date)

Dose #2: _____
(Date)

i. MEASLES (Rubeola) (mark all that apply)

1. Immunized with live vaccine at 12 months after birth or later. 2. Has report of positive immune titer. Specify date.

Dose #1: _____
(Date)

Dose #2: _____
(Date)

Titer: _____
(Date)

ii. MUMPS (mark all that apply)

1. Immunized with live vaccine at 12 months after birth or later. 2. Has report of positive immune titer. Specify date.

Dose #1: _____
(Date)

Dose #2: _____
(Date)

Titer: _____
(Date)

iii. RUBELLA (German Measles) (Clinical history is not acceptable) (mark all that apply)

1. Immunized with live vaccine at 12 months after birth or later. 2. Has report of positive immune titer. Specify date.

Dose #1: _____
(Date)

Titer: _____
(Date)

D. POLIO - RECOMMENDED

(Requested in case of international travel. Not required for registration)

Completed primary series? YES/NO (*circle one*) Last Dose: _____
(Date)

E. TETANUS-DIPHTHERIA - RECOMMENDED

Date: _____

F. HEPATITIS B - RECOMMENDED

Dose #1: _____ Dose #2: _____ Dose #3: _____
(Date) (Date) (Date)

G. VARICELLA (CHICKENPOX VACCINE) - RECOMMENDED

Dose #1: _____
(Date)

Dose #2: _____
(Date)

H. TUBERCULOSIS SCREENING (PPD)

REQUIRED OF ANY STUDENT WHO HAS EVER LIVED OUTSIDE THE US FOR 6 MONTHS OR MORE

Regardless of prior BCG inoculation; Tine or Monovac not acceptable.

Date: _____

POSITIVE

NEGATIVE

If positive (10 mm induration or greater), a chest X-ray within 1 year of registration is required.

Date: _____

NORMAL

ABNORMAL

If abnormal, attach copy of report.

If PPD was positive, was the student treated with INH for at least 6 months?

YES/NO (circle one)

Date Started: _____

Date Completed: _____

V. HEALTH CARE PROVIDER:

I have reviewed all of the information in Part III and certify that the information is complete and accurate:

Name: _____

Address: _____

Phone: _____

Signature: _____

Date: _____

VI. CONSENT TO MEDICAL AND/OR SURGICAL PROCEDURE

The laws of Maryland require that surgical and medical treatment of minors (individuals less than 18 years of age) be at the request of and with the approval of their parents (and spouse of a married minor). The right to request and approve may be delegated to officials of the University. It is our policy to notify parents as soon as possible in the event of major illness or injury. We find it impractical to notify for every minor illness or injury requiring treatment. It will help us to protect the health of your son or daughter if you will delegate to us discretion in these matters.

Requests are received from hospitals, other physicians, other universities, and insurance companies for information about conditions treated by us. Parents of minors (and spouse of a married minor) must approve the release of such information and may delegate this discretion to physicians providing Student Health Services for Peabody. It is our policy to disclose medical information at the request of the student in the belief that it will be used for ordinary medical and insurance purposes.

I/We hereby authorize the professional staff of Johns Hopkins Community Physicians, an affiliate of Johns Hopkins Health System, and/or any one of the Deans/Directors of the University, in the event I/we shall not be readily available in connection with the need for the consent hereinafter referred to consent to, and authorize, in my/our behalf, medical treatment and/or the performing of any operative and surgical procedure and under any anesthetic, either local or general, for myself/our son/daughter _____ (student's name) while a student at said University, as may be considered necessary or advisable by the physician performing such treatment or surgery, and/or to release to other physicians who may be treating me/our son/daughter, relevant medical information as to treatment accorded me/him/her through the University's Student Health provider.

Signature of Parent
or Legal Guardian: _____

Date: _____

Signature of Student: _____

Date: _____