

**\*Please Submit your completed Health Form to Velisha Hall by July 1, 2011\***

**Contact Velisha Hall at: Phone: 410-338-3357 Email: wymanparkim@jhmi.edu Fax: 410-338-3367**

**I. STUDENT INFORMATION - To be completed by Student**

Name	_____	Date of Birth	_____	Male/Female (circle one)
Home Address	_____	Home Phone	_____	
City, State, Zip	_____	Cell Phone	_____	
Country	_____	Email*	_____	
Mother's Name/Maiden	_____	*May we contact you regarding your health information at this e-mail address? YES/NO (circle one)		
Father's Name	_____			

**II. STUDENT MEDICAL INSURANCE INFORMATION - To be completed by Student**

All students must either purchase the University-sponsored insurance plan or complete a waiver showing proof of comparable coverage with another insurance provider. **The waiver deadline is September 30, 2011.** Students insured under any kind of managed care insurance plan should determine, prior to arrival at Peabody, the nature of their coverage for medical services while away at college.

I plan to purchase the school insurance.     I plan to waive the school insurance (complete information below).

Name of Company:	_____
Address:	_____
Phone Number:	_____
Policy Holder:	_____ Relationship: _____
Policy Number:	_____ Expiration Date: _____

Does this insurance coverage require preauthorization for laboratory tests, x-rays or hospitalizations? YES/NO (circle one)

**III. MEDICAL HISTORY - To be completed by Student**

	YES	NO
1. Have you ever lived outside the United States for a total of 6 months or more? (if yes, a negative PPD or negative chest x-ray is required within one year of registration. *See section H*)	_____	_____
2. Are you allergic to: <i>(If yes to any of the below, please provide details)</i>	_____	_____
<u>Name(s)</u> <u>Description of Reaction</u>		
<i>Medications?</i>	_____	_____
<i>Insect Bites?</i>	_____	_____
<i>Foods?</i>	_____	_____
3. Do you have hay fever, hives, other allergies not previously listed?	_____	_____
4. Do you smoke cigarettes?	_____	_____
5. Do you now have or have you ever been treated for any of the following:		
Asthma	_____	_____
Blood Disorder	_____	_____
Cancer	_____	_____
Diabetes Mellitus (Type I or Type II)	_____	_____
Eating Disorder (including but not limited to anorexia nervosa, bulimia nervosa)	_____	_____
Immune system disorder (e.g., Lupus, HIV/AIDS, immunosuppressive therapy, splenectomy)	_____	_____
Inflammatory bowel disease	_____	_____
Mental Health problems (e.g., depression, anxiety disorder, suicide attempts, etc.)	_____	_____
Seizure disorder <b>Date of last seizure:</b>	_____	_____
Substance abuse disorder	_____	_____
Surgeries or significant injuries	_____	_____
Thyroid disease or other endocrine disorder	_____	_____
Other chronic medical condition	_____	_____
Describe: _____		
6. Have you ever had chicken pox?	_____	_____
7. List any medications you take on a regular basis:	_____	_____

#### 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.

\_\_\_\_\_  
*(Specify name of vaccine)* Date: \_\_\_\_\_

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

##### 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: \_\_\_\_\_