STUDENT HEALTH AND EDUCATION SERVICES

HEALTH FORM AND IMMUNIZATION RECORD

LOYOLA UNIVERSITY MARYLAND

PLEASE COMPLETE BOTH SIDES OF THIS FORM. DO NOT SEND SEPARATE RECORDS. NO ATTACHMENTS WILL BE ACCEPTED.
Please complete information and return to Loyola University Maryland Student Health Center.

Part I.

NAME LAST | FIRST | MIDDLE

BIRTHDATE (MONTH / DAY / YEAR) | SEX ☐ Male ☐ Female | SOCIAL SECURITY NUMBER | STUDENT ID #

HOME ADDRESS

CITY | STATE / COUNTRY IF APPLICABLE | ZIP CODE

HOME TELEPHONE | CELL PHONE

Term Entering: ☐ Fall ☐ Spring Student Status: ☐ Freshman ☐ Transfer ☐ Grad Student

PERSON TO NOTIFY IN CASE OF AN EMERGENCY

NAME | RELATIONSHIP | HOME TELEPHONE | WORK TELEPHONE

PRIMARY PHYSICIAN/HEALTH INSURANCE

PHYSICIAN / PROVIDER NAME | TELEPHONE | FAX

ADDRESS | CITY | STATE | ZIP

HEALTH INSURANCE COMPANY / HMO | POLICY NUMBER | GROUP NUMBER

ADDRESS | CITY | STATE | ZIP

MEDICAL HISTORY

Allergies (Please list any allergies to drugs, food, insect, stings, etc.– specify drug allergies)

Please tell us about any chronic health conditions, disabilities, serious illnesses or medications which may impact your health status while at Loyola University Maryland. Attach pertinent medical records.

Part II.

PARENTAL CONSENT TO MEDICAL AND/OR SURGICAL TREATMENT OF MINOR

To be completed by the parents or guardians of students who will be younger than 18 upon arrival on campus.

The laws of Maryland require that surgical and medical treatment of minors and release of medical information to hospitals, other physicians, and insurance companies about conditions treated by us be at the request of and with the approval of their parents. This right to request an approval may be delegated to University officials. Although it is our policy to notify the parents as soon as possible in the event of major illness or injury, it is impractical to notify for every minor illness or injury requiring treatment. It will help us protect the health of your child if you will delegate to use discretion in these matters. I give my permission for such diagnostic and therapeutic procedures as may be deemed necessary for my son/daughter and agree to present information concerning his/her medical condition to other responsible University officials when deemed desirable. No major operations will be performed, except in extreme emergency, without parents being fully informed.

Signature of Parent or Legal Guardian_____ Date _____

Signature of Student_____ Date _____

— PLEASE CONTINUE ON BACK —

NAME LAST | FIRST | MIDDLE

DATE OF BIRTH | STUDENT ID # | SS#

Part III. Immunization Record

TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER. All information must be in English.

PREMATRICULATION REQUIREMENTS

A. TETANUS-DIPHTHERIA (TDAP)

1. Tetanus given within the last ten years ..... ____/____/____ (MONTH DAY YEAR)

B. POLIO (OPV or IPV)

1. Completed primary series of polio immunization: ☐ Yes ☐ No Date of last booster: ..... ____/____/____ (MONTH DAY YEAR)

C. MEASLES, MUMPS, RUBELLA - Proof of Immunity Required

MMR (Measles, Mumps, Rubella) –2 doses required

1. Dose 1 – Immunized at 12 months after birth or later ..... ____/____/____ (MONTH DAY YEAR)
2. Dose 2 – Immunized at any time 1 month after dose #1 ..... ____/____/____ (MONTH DAY YEAR)

D. TUBERCULOSIS – Testing required for entrance (Regardless of prior BCG inoculation)

1. PPD (Mantoux) test within 6 months prior to admission
   Give date, results, and measurement of induration ..... Date Adminstered ____/____/____ (MONTH DAY YEAR)
   Result: Negative_____ Positive_____ Complete mm results_____ mm ..... Date Read ____/____/____ (MONTH DAY YEAR)
2. Chest x-ray required if ≥ 10mm induration (Attach copy of chest x-ray report)
   Give date and result of chest x-ray ..... Result: ☐ Normal ☐ Abnormal ____/____/____ (MONTH DAY YEAR)
3. Document any treatment (INH or other) received. If history of active TB, document completed TB therapy. (Attach copies of documentation)

E. MENINGOCOCCAL VACCINE (Required by Maryland State Law) ..... ____/____/____ (MONTH DAY YEAR)

Menactra ☐ Menveo ☐ (after age 16)

F. HEPATITIS B VACCINE..... Dose #1 ____/____/____ (MONTH DAY YEAR) Dose #2 ____/____/____ (MONTH DAY YEAR) Dose #3 ____/____/____ (MONTH DAY YEAR)

G. VARICELLA (Chickenpox)

1. Had disease, confirmed by office record ..... ____/____/____ (MONTH DAY YEAR)
2. Has report of positive immune titer. Specify date ..... ____/____/____ (MONTH DAY YEAR)
3. Varicella vaccine ..... Dose #1 ____/____/____ (MONTH DAY YEAR) Dose #2 ____/____/____ (MONTH DAY YEAR)

HEALTH CARE PROVIDER

NAME

ADDRESS | CITY | STATE | ZIP

SIGNATURE | TELEPHONE | DATE

LOYOLA STUDENT HEALTH REVIEWER | DATE

Information on this form is CONFIDENTIAL. It is for the Health Center's use only and will not be released without the student's written consent and will not affect admission status.