STUDENT HEALTH AND EDUCATION SERVICES



HEALTH FORM AND IMMUNIZATION RECORD

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.

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NAME LAST	FIRST	MIDDLE	
□ Male □ Female BIRTHDATE (MONTH / DAY / YEAR) SEX	SOCIAL SECURITY NUMBER	STUDENT ID #	
HOME ADDRESS			
CITY	STATE / COUNTRY IF APPLICABLE	ZIP	
HOME TELEPHONE	CELL PHONE		
Term Entering: □ Fall □ Spring Student Status	☐ First-Year Student ☐ 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, in	sects, stings, etc specify drug allergies.)		
Please tell us about any chronic health conditions, Loyola University Maryland. Attach pertinent medic	disabilities, serious illnesses, or medications which r al records.	nay impact your healt	:h status while at
Part II.			
PARENTAL CONSENT TO MEDICAL AND/OR SURGIC	AL TREATMENT OF MINOR		
Maryland law requires surgical and medical treatment of mir treated by Loyola University Maryland Student Health Cente delegated to University officials. It is our policy to notify a sl for every minor illness or injury requiring treatment. It will he	of students who will be younger than 18 upon ors and release of medical information to hospitals, physicial r be at the request of and with the approval of their legal guudent's guardians as soon as possible in the event of major is elp us protect the health of your child and expedite their care med—except in extreme emergency—without first informing	ns, and insurance compar ardians. This right to requ Ilness or injury; however, a if you delegate for the U	nies regarding conditions uest an approval may be it is impractical to do so
I give my permission for such diagnostic and therapeutic p his/her medical condition to other responsible University of	rocedures as may be deemed necessary for my son/daughte ficials when deemed desirable.	er and agree to present i	nformation concerning
Signature of Parent or Legal Guardian		Date	
Signature of Student		Date	

NAME LAST	FIRST	MIDDLE	
DATE OF BIRTH	STUDENT ID #	SS#	
Part II. Immunization Reco	ord YOUR HEALTH CARE PROVIDER. All information	must be in English.	
PREMATRICULATION REQUIREME	INTS		
A. TDAP (Tetanus-Diphtheria-Peri B. POLIO (OPV or IPV) 1. Completed primary series of	tussis) polio immunization: □Yes □No Date o	f last booster:	
C. MEASLES, MUMPS, RUBELLA - MMR (Measles, Mumps, Rubella 1. Dose 1 - Immunized at 12 mo 2. Dose 2 - Immunized at any t	a) – 2 doses required onths after birth or later		///
3. Proof of immune titers (Atta	ch)		MONTH DAY YEAR
1. PPD (Mantoux) test within 6 Date, results, and measurem Result: Negative Posit 2. Chest x-ray required if \(^2\) 10	ired for high risk students and international streamonths prior to admission sent of induration	Date Adminstered Date Read	MONTH DAY YEAD
3. Document any treatment (INH o	or other) received. If history of active TB, docu		
Menactra Mo	Required by Maryland State Law) enveo (after age 16) ose #1 ———————————————————————————————————		MONTH / DAY / YEAR #3/
G. VARICELLA (chicken pox) 1. Had disease, confirmed by of 2. Has report of positive immure	ffice recordne titer. Specify date		
3. Varicella vaccine	Dose #1	Month Day YEAR Dose	MONTH DAY YEAR MONTH DAY YEAR 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. It will not be released without the student's written consent and will not affect admission status.

