LOYOLA
UNIVERSITY MARYLAND

STUDENT HEALTH AND EDUCATION SERVICES

HEALTH FORM AND IMMUNIZATION RECORD

DO NOT SEND SEPARATE RECORDS.
INCLUDE ATTACHMENTS ONLY IF SPECIFIED.

Complete and return to:
Loyola University Maryland
Student Health Center
4502A N. Charles St.
Baltimore, MD 21210

STUDENT INFORMATION

NAME LAST | FIRST | MIDDLE

BIRTHDATE (MONTH / DAY / YEAR) ☐☐-☐☐-☐☐ | ☐ Male ☐ Female 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 | PRIMARY TELEPHONE

HEALTH INSURANCE

NAME OF POLICY HOLDER

HEALTH INSURANCE COMPANY / HMO | POLICY NUMBER | GROUP NUMBER

ADDRESS | CITY | STATE | ZIP

MEDICAL HISTORY

List any allergies to drugs, food, insects, etc. Specify any drug intolerance.

Tell us about any chronic health conditions, disabilities, serious illnesses, or medications that may impact your health status while at Loyola University Maryland. We may request additional records if treatment is to be given at the Student Health Center.

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.

Maryland law requires surgical and medical treatment of minors and release of medical information to hospitals, physicians, and insurance companies regarding conditions treated by Loyola University Maryland Student Health Center be at the request of and with the approval of their legal guardians. This right to request an approval may be delegated to University officials. It is our policy to notify a student's guardians as soon as possible in the event of major illness or injury; however, it is impractical to do so for every minor illness or injury requiring treatment. It will help us protect the health of your child and expedite their care if you delegate for the University to use discretion in these matters. Major medical operations will not be performed—except in extreme emergency—without first informing a student's guardians.

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.

Signature of Parent or Legal Guardian _____ Date _____

Signature of Student _____ Date _____

REVERSE SIDE TO BE COMPLETED BY YOUR HEALTH CARE PROVIDER

NAME LAST | FIRST | MIDDLE

DATE OF BIRTH | STUDENT ID # | SOCIAL SECURITY #

IMMUNIZATION RECORD

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

PREMATRICULATION REQUIREMENTS

A. **TDAP** (Tetanus-Diphtheria-Pertussis) ..... _____/_____/_____ (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)

Or proof of immune titers ***(Attach)***

D. **TUBERCULOSIS** – ***Testing required for high-risk students only***

1. Tbc test within 6 months prior to admission
Date, results, and measurement of induration if PPD (Mantoux) ..... 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)***
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)
(after age 16)

F. **HEPATITIS B VACCINE** _____/_____/_____ (MONTH/DAY/YEAR) _____/_____/_____ (MONTH/DAY/YEAR) _____/_____/_____ (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 ..... _____/_____/_____ (MONTH/DAY/YEAR)

HEALTH CARE PROVIDER

NAME

ADDRESS | CITY | STATE | ZIP

SIGNATURE | TELEPHONE | DATE

PRINT NAME

**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.**

**Loyola University Maryland Student Health Center · 4502A N. Charles St. · Baltimore, MD 21210
410-617-5055 · FAX 410-617-2173**

REV. 2/15