LOYOLA
UNIVERSITY MARYLAND

Complete and return to:

Loyola University Maryland
Student Health Services
4502A N. Charles St.
Baltimore, MD 21210
OR
Fax: (410) 617-2173
Phone: (410) 617-5055

STUDENT HEALTH SERVICES HEALTH FORM

PART I: TO BE COMPLETED BY STUDENT/PARENT/GUARDIAN.

Please return form when both Part I and Part II are complete.

DUE DATES: **JULY 25 (FALL ADMISSION)** **JANUARY 15 (SPRING ADMISSION)**

STUDENT INFORMATION

LAST NAME FIRST NAME MIDDLE INITIAL BIRTHDATE (MONTH/DAY/YEAR)

GENDER LOYOLA EMAIL ADDRESS CELL PHONE NUMBER STUDENT ID #

HOME ADDRESS

CITY STATE / COUNTRY IF APPLICABLE ZIP

Term Entering: Fall Spring Class Status: First-Year Transfer Graduate

IN CASE OF AN EMERGENCY, NOTIFY

NAME RELATIONSHIP CELL PHONE NUMBER ALTERNATE PHONE NUMBER

MEDICAL HEALTH HISTORY

ALLERGIES

Are you allergic to any **medications/drugs**? (e.g. penicillin/sulfa) Yes No

Which medication/drug, and what is your reaction? ______

Are you allergic to any **foods**? (e.g. peanuts, tree nuts, shellfish, milk) Yes No

Which foods, and what is your reaction? ______

Do you have any other **allergies**? (e.g. dust, pollen, latex, animal dander) Yes No

Which allergens, and what is your reaction? ______

Do you have an EpiPen? Yes No

MEDICATIONS *Please list all medications you are taking regularly, including prescribed, over-the-counter, and herbal/natural remedies.*
Please include drug name/dose/frequency (e.g., multi-vitamin 1 tablet once a day)

______

______

MEDICAL ILLNESSES/CONDITIONS *Please list all medical problems that other doctors have diagnosed.*

______

______

MENTAL HEALTH/CONDITIONS *Please list all mental health problems that other doctors have diagnosed.*

______

SURGERY *Please list the approx. year and surgery.*

YEAR TYPE OF SURGERY

HOSPITALIZATION *Please list approx. year and reason for hospitalization.*

YEAR REASON

ALL THE INFORMATION YOU HAVE PROVIDED IS MAINTAINED AS CONFIDENTIAL
WITHIN STUDENT HEALTH SERVICES AND WILL NOT BE SHARED.

STUDENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL
DATE OF BIRTH	STUDENT ID #	CELL PHONE NUMBER

STUDENT HEALTH INSURANCE

In an effort to ensure students' physical and financial health, Loyola University Maryland requires ALL full-time undergraduate students to have health insurance during the academic year.

You are required to visit **www.firststudent.com** and either (1) enroll in the Loyola-sponsored student health insurance plan, or (2) submit a request to waive coverage. To waive coverage, your plan must have comparable coverage based on Loyola's waiver criteria. Please review your current plan to be sure that your benefits extend to the Maryland area.

DISABILITY SERVICES

Students with documented disabilities should register with Disability Support Services at **(410) 617-2750** to ensure their specific academic, residential, and/or dining needs will be addressed during their time at Loyola. For more information and/or registration, please access their website at **www.loyola.edu/dss.**

CONSENT TO MEDICAL AND/OR SURGICAL TREATMENT

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 services 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.

STUDENT SIGNATURE (IF 18 OR OLDER)	PRINT NAME	DATE
PARENT/LEGAL GUARDIAN SIGNATURE (IF STUDENT IS UNDER 18)	PRINT NAME	DATE

PLEASE RETAIN A COPY OF THESE FORMS FOR YOUR RECORDS

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STUDENT HEALTH SERVICES HEALTH FORM

PART II: TO BE COMPLETED BY HEALTH CARE PROVIDER.
Please Note: *print-outs/attachments can supplement but NOT substitute for form completion.*

STUDENT INFORMATION

LAST NAME ____________ FIRST NAME ____________ MIDDLE INITIAL ____________

DATE OF BIRTH ____________ STUDENT ID # ____________ CELL PHONE NUMBER ____________

REQUIRED VACCINATIONS

1. **MEASLES, MUMPS, RUBELLA** (2 doses, at least 1 month apart OR positive titers) **Dose 1:** ____/____/____ (MONTH DAY YEAR) **Dose 2:** ____/____/____ (MONTH DAY YEAR)

   POSITIVE Measles, Mumps, and Rubella IgG Titers *(copy of lab report MUST be attached)*

2. **MENINGITIS ACWY (at age 16 or older) -** ***Required by Maryland State Law.*** .... ____/____/____ (MONTH DAY YEAR)

3. **POLIO** (OPV or IPV)

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

4. **TDAP** (Tetanus-Diphtheria-Pertussis within the last ten years) .... ____/____/____ (MONTH DAY YEAR)

5. **VARICELLA (2 doses, at least 1 month apart OR positive titers OR physician documentation of Varicella disease)**

   Dose 1: ____/____/____ (MONTH DAY YEAR) **Dose 2:** ____/____/____ (MONTH DAY YEAR)

   POSITIVE Varicella IgG Titer *(copy of lab report MUST be attached)* Varicella *(physician documentation of Varicella disease)*

6. **TUBERCULOSIS SCREENING TEST - Complete TB risk assessment below.**

   Yes No Spent time with someone who has TB disease

   Yes No Is from a country where TB is common *(most countries in Latin America, the Caribbean, Africa, Asia, Eastern Europe, and Russia)*

   Yes No Lives/works in high-risk setting *(e.g., correctional facilities, long-term care facilities or nursing homes, homeless shelters)*

   Yes No Is a health care worker who cares for patients

   Yes No Has been exposed to someone who was at increased risk for latent tuberculosis infection/TB disease

   Yes No Is registered at Loyola as an International Student

If the answer is "YES" to any of the above questions, the student must have a TB test (PPD or blood test).
If the answer is "NO" please skip to next page.

HISTORY OF NEGATIVE TB TEST Date of negative test ____/____/____ (MONTH DAY YEAR) Test used ____________

OR

HISTORY OF POSITIVE TB TEST Date of positive test ____/____/____ (MONTH DAY YEAR) Test used ____________

CXR Results ____________ Date of CXR ____/____/____ (MONTH DAY YEAR)

Treatment Received: Yes No

If the answer is YES Start Date ____/____/____ (MONTH DAY YEAR) Stop Date ____/____/____ (MONTH DAY YEAR)

Name of Medication ____________

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STUDENT INFORMATION

LAST NAME ______ FIRST NAME ______ MIDDLE INITIAL ______

DATE OF BIRTH ______ STUDENT ID # ______ CELL PHONE NUMBER ______

RECOMMENDED VACCINATIONS - THESE VACCINES ARE RECOMMENDED, BUT NOT REQUIRED.

1. **INFLUENZA (annually for all ages, preferably in September/October)** .... ____/____/____ MONTH DAY YEAR

2. **GROUP B MENINGITIS** **BEXSERO** **TRUMENBA**

   Dose 1: ____/____/____ MONTH DAY YEAR **Dose 2:** ____/____/____ MONTH DAY YEAR **Dose 3:** ____/____/____ MONTH DAY YEAR

3. **HEPATITIS A** (2 doses, at least 6 month apart)

   Dose 1: ____/____/____ MONTH DAY YEAR **Dose 2:** ____/____/____ MONTH DAY YEAR

4. **HEPATITIS B** (3 doses in 6 months)

   Dose 1: ____/____/____ MONTH DAY YEAR **Dose 2:** ____/____/____ MONTH DAY YEAR **Dose 3:** ____/____/____ MONTH DAY YEAR

5. **HUMAN PAPILLOMA VIRUS** (if student is 26 years old or younger)

   Dose 1: ____/____/____ MONTH DAY YEAR **Dose 2:** ____/____/____ MONTH DAY YEAR **Dose 3:** ____/____/____ MONTH DAY YEAR

HEALTH CARE PROVIDER:

PRACTITIONER'S SIGNATURE ______ PRINT NAME AND TITLE ______ DATE ______

CITY ______ STATE ______ ZIP ______ PHONE NUMBER ______ FAX NUMBER ______

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