

PLEASE COMPLETE AND SUBMIT HEALTH FORM IMMEDIATELY OR YOU MAY JEOPARDIZE YOUR CLASS SCHEDULE!

Mail or fax to: Dowell Health Center, 8000 York Road, Towson, MD 21252-0001 ▪ t. 410-704-2466 / f. 410-704-3715

U.S. CITIZEN OR PERMANENT RESIDENT

PART I: To be completed by student. All information is strictly confidential. No information will be released without your consent.

Last Name _____ First Name _____ MI _____ Sex: M F TU ID # _____

E-mail Address _____ Term Entered: Fall Spring of year: _____

Permanent Address _____

Student Signature _____

EMERGENCY CONTACT (If attending classes at Towson campus):

Name _____

Home Phone _____ Work Phone _____ Mobile Phone _____

HEALTH INSURANCE INFORMATION (Please complete if attending classes at Towson campus):

Plan _____ Policy ID # _____ Group # _____

Subscriber's Name _____ Phone number to call for authorizations _____

HEALTH INFORMATION (Please complete if attending classes at Towson campus):

ALLERGIES: Please list any allergies to drugs below. Also, list any allergies to food, insect stings, etc.

Name of drug or other allergy	Type of reaction	Name of drug or other allergy	Type of reaction

MEDICATIONS: List all medications you take regularly, including contraceptives and non-prescription drugs.

Name of drug	Strength/dosage	Name of drug	Strength/dosage

Please tell us about any chronic health conditions, disabilities, chronic/serious illnesses that may impact your health status while at Towson University:

PART II. PARENTAL CONSENT TO TREATMENT OF A MINOR (If student will be under 18 at arrival on campus)

I hereby authorize the professional staff of the Dowell Health Center of Towson University to carry out or to request such diagnostic and therapeutic measures for my son/daughter _____ as may be considered necessary or advisable by the treating provider. I also authorize the release to other physicians who may be treating my son/daughter, relevant medical information as to treatment provided my son/daughter through the university's Student Health Service. I understand I will be notified as soon as possible in the event of life-threatening illness or injury.

Signature of Parent or Legal Guardian _____ Date _____

STUDENT NAME: _____ Date of Birth: (mm/dd/yy) _____ TU ID # _____

PART III. REQUIRED AND SUGGESTED IMMUNIZATIONS: This form must be completed and signed by a health care provider.

R=Required S=Suggested	VACCINE	DOSE 1	DOSE 2	DOSE 3	Antibody Titer Results ¹	History of Disease
R	Measles-Mumps-Rubella ²	___/___/___	___/___/___		Attach Copy	
R	Tetanus-Diphtheria- Pertussis ³	Primary series (5 doses DT, DTP, DTaP or Td) completed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Tdap (single dose required at/after 11 yrs. of age): ___/___/___ Td (if ≥10 yrs. since last Tdap booster) Last booster: ___/___/___		
R if living on campus	Meningococcal Vaccine ⁴	MCV4 given on/after 2/1/06 <input type="checkbox"/> Menactra <input type="checkbox"/> Menveo ___/___/___				
S	Hepatitis B ⁵	___/___/___	___/___/___	___/___/___	Attach Copy	___/___/___
S	Varicella ⁶	___/___/___	___/___/___		Attach Copy	___/___/___
S	HPV ⁷	___/___/___	___/___/___	___/___/___		

TUBERCULOSIS SKIN TEST: Required ONLY if you were born or have lived outside the United States or Canada for more than six months: Intradermal PPD (Mantoux) skin test performed in the U.S. within the last year. TB Tine Test or Monovac NOT acceptable.

A. Date PPD performed: _____ Date PPD read*: _____ Result*: _____ mm induration
(Must be read within 48–72 hrs.)

B. If PPD is positive, attach **copy of official negative chest X-ray report** performed in United States after the positive PPD test.
(Do not send copy of actual X-ray.)

C. Document any treatment you have received for either a positive TB skin test or active tuberculosis disease:

Medication received: _____ Dates of treatment: _____

EXEMPTION FROM REQUIRED IMMUNIZATIONS:

- Medical** (Letter from health care provider explaining contraindication to specific vaccine(s).)
- Religious** (Request for Exemption Form must be completed and notarized. Form is available at Dowell Health Center.)

HEALTH CARE PROVIDER (PRINT NAME): _____ Date: _____

HEALTH CARE PROVIDER SIGNATURE: _____

¹ Must attach copy of antibody titer results, not just enter "positive" or "negative"
² Two doses of Measles-Mumps-Rubella (MMR) at least one month apart, given on or after first birthday are required. May substitute blood titers showing immunity to measles, mumps and rubella. Students born before Jan. 1, 1957, presumed immune to measles, mumps, rubella.
³ Primary series required (5 doses of DT, DTP, DTaP or Td). One dose of Tdap required at ≥11 yrs of age to replace single decennial Td booster dose. Td booster every 10 years thereafter.
⁴ One dose of quadrivalent conjugate vaccine (MVC4: Menactra or Menveo) given within last 5 yrs required of all students living on campus, unless waiver signed.
⁵ Hepatitis B vaccine series or titer proof of immunity strongly recommended. May be required for Health Professions students.
⁶ Varicella vaccine series or titer proof of immunity strongly recommended. May be required for Health Professions students. 2 doses (12 weeks apart for <12 year olds, 4 weeks apart for >13 year olds.)
⁷ HPV vaccine strongly recommended for men and women age 9–26 years. Vaccine available at the Dowell Health Center.

