

This completed form must be returned to Student Health within eight weeks after the date received. Registration will NOT be complete until this requirement is met.

Items A-E MUST be completed and signed by a health care provider or a copy of the records must be attached.

A. Td or Tdap (Must be within the past 10 years) Date: ___/___/___

B. MMR (Measles, Mumps, Rubella) – 2 doses are required. If MMR was not given please skip to B1, 2, & 3.

Date of 1st Dose (Given on or after 1st birthday) Date: ___/___/___

Date of 2nd Dose Date: ___/___/___

1. Measles (Rubeola) – (If given instead of MMR)

Born before January 1, 1957 considered immune

Had disease (Must attach record copy) Date: ___/___/___

Titer Immune Non-Immune Date: ___/___/___

Immunized with live measles vaccine – 2 doses are required on or after 1st birthday

Date of 1st Dose Date: ___/___/___

Date of 2nd Dose Date: ___/___/___

2. Rubella (If given instead of MMR)

Had disease (Must attach record copy) Date: ___/___/___

Titer Immune Non-Immune Date: ___/___/___

Immunized with vaccine at age 1 or older Date: ___/___/___

3. Mumps (If given instead of MMR)

Had disease (Must attach record copy) Date: ___/___/___

Titer Immune Non-Immune Date: ___/___/___

Immunized with vaccine at age 1 or older Date: ___/___/___

C. Varicella (Chickenpox)

Had disease (Patient History Accepted) Date: ___/___/___

Titer Immune Non-Immune Date: ___/___/___

Immunized with vaccine – 2 doses are required

Date of 1st Dose Date: ___/___/___

Date of 2nd Dose Date: ___/___/___

D. Hepatitis B (Not required for Law students)

Dates received: First Dose: ___/___/___ Second Dose: ___/___/___ Third Dose: ___/___/___

or Titer Immune Non-Immune Date: ___/___/___

E. Tuberculosis (PhD & Law students are only required to have one PPD within the past year)

You must provide proof of two tuberculosis skin tests (TST) at least one week apart, done within the last 12 months.

If you have a positive result, you must attach a copy of a Chest X-ray report. Please also include dates of prophylaxis therapy, if completed.

TST 1 Placement Date ___/___/___ Read Date ___/___/___ Result (mm of induration) Readers Initials

TST 2 Placement Date ___/___/___ Read Date ___/___/___ Result (mm of induration) Readers Initials

Please describe any disability as well as any accommodation that may be required from Student Health. Students should convey directly to their school administration the need for an accommodation within the school or related to their program of study.

PHYSICIAN SIGNATURE: _____ PHONE: _____ DATE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

STATEMENT BY STUDENT: I have personally supplied all the above information and attest that it is true and complete to the best of my knowledge.

STUDENTS NAME (Please Print): _____
Last First Middle SS#

Student Signature: _____ Date: _____

The space below is reserved for use by the University of Maryland Baltimore Student Health Personnel

Student Health Reviewer: _____ **Date Completed:** _____

IMMUNIZATION & MEDICAL HISTORY
Student Health
University of Maryland, Baltimore
29 South Paca Street • Lower Level • Baltimore, Maryland 21201
(410)328-6791 Phone • (410)328-7924 Fax
shealth@som.umaryland.edu

MAKE A COPY OF THIS COMPLETED FORM FOR YOUR OWN RECORDS.

| | | | | |
|--|----------------|-------------|------------------------|---------------|
| Last Name (Print Above) | First Name | Middle Name | Social Security Number | |
| Date of Birth | Place of Birth | Age | Sex | Email Address |
| Local Address | City | State | Zip Code | Phone Number |
| Home Address (If different from above) | City | State | Zip Code | Phone Number |
| Person to Notify in Case of Emergency | Relationship | Home Phone | Cell Phone | Work Number |

Date of Entrance: Fall Spring Summer 20_____

FAMILY HISTORY

Have any of your relatives ever had the following?

| | YES | NO | RELATIONSHIP |
|-----------------------|-----|----|--------------|
| Anemia (Type) | | | |
| Arthritis | | | |
| Cancer | | | |
| Diabetes | | | |
| Epilepsy, Convulsions | | | |
| Heart Disease | | | |
| High Blood Pressure | | | |
| High Cholesterol | | | |
| Kidney Disease | | | |
| Tuberculosis | | | |

Program you are entering (Check One)

- Dental Dental Hygiene PG Dental Medicine
- Graduate School (Ph.D.) Pathology Assistant
- Genetic Counseling Law Physical Therapy
- Medical Research Technology Pharmacy
- Nursing (Please specify - BSN or MS) Social Work MSW

PLEASE LIST ALL MEDICATIONS YOU USE, REASON & DOSAGE (Please include prescriptions, birth control & any over the counter medication).

PLEASE LIST ANY ALLERGIES & THEIR REACTIONS (Please include skin, food, respiratory & drug allergies).

PAST MEDICAL HISTORY

Have you ever been a patient in any type of hospital? Yes No If yes, list when, where and why. _____

Do you have any major medical problems? Yes No If yes, explain. _____

Do you have any other concerns about your health? Yes No If yes, please explain. _____
