



THIS FORM IS REQUIRED!! FAILURE TO SUBMIT YOUR HEALTH AND IMMUNIZATION FORM BY THE DEADLINE WILL AFFECT YOUR ACCESS TO CLASS SCHEDULING. PLEASE SEE IMPORTANT INFORMATION ON PAGE 2.

Last Name	First Name	Middle Name	UMES ID#
Home Address	City	State	Zip
Home Phone	Cell phone	e-mail address	Date of Birth
Term Entered: <input type="checkbox"/> Fall <input type="checkbox"/> Spring <input type="checkbox"/> Summer of year _____		<input type="checkbox"/> U.S. Citizen	<input type="checkbox"/> Perm. Resident <input type="checkbox"/> International
Emergency contact's name and address		Relationship	Home Phone Bus. Phone

Health Insurance Information

Yes, I have health insurance [attach a copy of the front and back of your insurance card] **No**, I am not currently covered

PERSONAL HISTORY: Please answer all questions. Explain any "yes" answers						FAMILY HISTORY: For any "yes" - indicate which relative			
Yes	No	Have you ever had:	Yes	No	Have you ever had:		Yes	No	Have any of your blood relatives had:
		ANEMIA			HIGH CHOLESTEROL				BLEEDING DISORDER
		ARTHRITIS			KIDNEY DISEASE				CANCER
		ASTHMA			LEUKEMIA / LYMPHOMA				DIABETES
		BACK / JOINT PROBLEMS			LUPUS				EPILEPSY
		BLOOD CLOTS/BLEEDING DISORDER			MAJOR SURGICAL PROCEDURES				HEART ATTACK / HEART DISEASE
		CANCER			MALARIA				HIGH BLOOD PRESSURE
		DIABETES			MENSTRUAL PROBLEMS				HIGH CHOLESTEROL
		EMOTIONAL PROBLEM / DEPRESSION			MIGRAINES				KIDNEY DISEASE
		EYE PROBLEMS			MONONUCLEOSIS				MENTAL ILLNESS
		FAINTING			NEUROLOGICAL / NERVE CONDITIONS				STROKE
		GASTROINTESTINAL PROBLEMS			SEIZURES				THYROID PROBLEMS
		GYNECOLOGICAL PROBLEMS			SICKLE CELL DISEASE / TRAIT	MEDICATIONS: List any medications you take regularly:			
		HANDICAPS / DISABILITIES			SKIN DISORDER				
		HEART PROBLEMS / HEART MURMUR			THYROID DISORDER				
		HEPATITIS / LIVER DISEASE			TUBERCULOSIS				
		HERNIA			AIDS / HIV	ALLERGIES: List any medication, food you are allergic to:			
		HIGH BLOOD PRESSURE			OTHER SERIOUS ILLNESS				
		DO YOU DRINK ALCOHOL? # DRINKS PER WEEK			DO YOU SMOKE? # PACKS PER WEEK # YEARS				

COMMENTS: Explain any "yes" answers:

PARENTAL CONSENT (for students under age 18)

I give permission for such diagnostic and therapeutic procedures that may be deemed necessary for my son/daughter and to present information concerning his/her medical condition to other responsible medical personnel when deemed necessary.

Signed

Relationship

Date

IMPORTANT!! INFORMATION ABOUT IMMUNIZATIONS

These are UMES general admission requirements. Specialty programs in Health Professions may require additional information.

Who: All students, including graduate, transfer and international, full or part-time

- **Athletes:** Submit this health history and immunization form to Student Health, and send copies to the Athletic Department
- **Health Professions:** Submit original forms to Student Health and copies with additional requirements to your department

What: Health forms include Health History form*, immunization documentation*, copy of insurance card

- *Forms can be found at www.umes.edu/studenthealth

- **Health History form:** to be filled out by the student
- **Immunization documentation:** (see form for specifics) completed immunization form signed by a health care provider, copy of high school immunization record, personal medical records from your physician, military immunization records or international certificate of vaccination. *Attach copies to the health history form.*

No records:

- Blood tests called titers can be ordered by your health care provider for MMR, varicella and Hepatitis B to prove immunity
- A blood test for TB (Quantiferon) can also be ordered. Send the actual copies of the lab test report to us.

When: Deadline for submission of health and immunizations records:

- FALL SEMESTER: AUGUST 1
- SPRING SEMESTER: JANUARY 1

Remember: Maintain copies of all your records for your files

Submit records directly to Charles R. Drew Student Health Center by **mail, fax or e-mail** (including your health information with other correspondence to the university may cause a delay in handling).

Contact us:

Charles R. Drew Student Health Center

1 College Backbone Road

Princess Anne, MD 21853

Phone: 410-651-6597

fax: 410-651-6702

studenthealth@umes.edu

www.umes.edu/studenthealth

Failure to submit your health and immunization form by the deadline will affect your access to class scheduling.
You may mail, fax or email. Please keep a copy for your records.

UMES IMMUNIZATION RECORD

Student's Name: _____ Date of Birth ____/____/____ UMES ID#: _____

TO BE COMPLETED AND SIGNED BY HEALTH CARE PROVIDER

*** REQUIRED ***

A. M.M.R. (Measles, Mumps, Rubella) *(Two doses required unless born before 1957 or titer provided)*

- Dose 1 given at age 12-15 months or later#1 ____ / ____ / ____
- Dose 2 given at age 4-6 years or later, and at least one month after first dose#2 ____ / ____ / ____
- Copy of blood test (titer) showing immunityForm Attached

B. TUBERCULOSIS SCREENING (TB skin test or TB blood test **required within the past 12 months** – History of BCG vaccination should not preclude testing)

- TB blood test (Quantiferon Gold or T-spot) – **recommended for foreign born or foreign travel students**

Date drawn ____/____/____ Result: _____ (attach copy of lab report)

OR

- Tuberculin Skin Test: (Mantoux only)

Date given: ____/____/____ Result: _____ (Record actual mm of induration)

Date read: ____/____/____ Positive____ Negative____

- Chest x-ray (required if tuberculin skin test or TB blood test is positive)

Date of chest x-ray: ____/____/____ Result: normal____ abnormal____
(attach copy of report- do not send actual x-ray)

- Documentation of completion of INH / Rifampin regimen should be provided if applicable

C. *MENINGOCOCCAL *(one dose of MCV4 vaccine given on or after 16 years of age). *Required for students living in campus housing*

- Meningitis vaccineDate ____ / ____ / ____
- Meningitis B vaccineDate ____ / ____ / ____
- Declined – sign the enclosed waiver and attach

D. HPV

- Date ____ / ____ / ____ Date ____ / ____ / ____ Date ____ / ____ / ____

E. TETANUS-DIPHTHERIA *(Td booster within the last ten years)*

- Tetanus-Diphtheria ____ / ____ / ____
- TDAP ____ / ____ / ____

F. Varicella

- Date ____ / ____ / ____ Date ____ / ____ / ____ Titer ____ / ____ / ____

*** RECOMMENDED ***

HEALTH CARE PROVIDER

Name (Printed) _____ Address _____

Signature _____ Phone _____

MENINGITIS ON CAMPUS

KNOW YOUR RISK

LEARN ABOUT VACCINATION/ WAIVER

Certain college students are at increased risk for meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis. In fact, freshmen living in dorms are found to have a six fold increased risk for the disease. A U.S. health advisory panel recommends that college students, particularly freshmen living in dorms, learn more about meningitis and vaccination.

What is meningococcal meningitis?

Meningitis is rare. But when it strikes, this potentially fatal bacterial disease can lead to swelling of fluid surrounding the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even death.

How is it spread?

Meningococcal meningitis is spread through the air via respiratory secretions or close contact with an infected person. This can include coughing, sneezing, kissing or sharing items like utensils, cigarettes and drinking glasses.

What are the symptoms?

Symptoms of meningococcal meningitis, often resemble the flu and can include high fever, severe headache, stiff neck, rash, nausea, vomiting, lethargy and confusion.

Who is at risk?

Certain college students, particularly freshmen who live in dormitories or residence halls, have been found to have an increased risk for meningococcal meningitis. Other undergraduates can also consider vaccination to reduce their risk for the disease.

Can meningitis be prevented?

Yes. A safe and effective vaccine is available to protect against four of the five most common strains of the disease. The vaccine provides protection for approximately three to five years. As with any vaccine, vaccination against meningitis may not protect 100 percent of all susceptible individuals.

For more information: To learn more about meningitis and the vaccine visit or call *UMES Charles R. Drew Student Health Center* (410-651-6597). You may also visit the websites of the Centers for Disease Control and Prevention (CDC), www.cdc.gov/ncidod/dbmd/diseaseinfo, and the American College Health Association, www.acha.org.

MENINGITIS VACCINE WAIVER

I understand that under Maryland law students enrolled in a Maryland institution of higher education and who reside in on-campus student housing are required to be vaccinated against meningococcal disease, or may seek exemption from this law. I have read the meningitis information available on the reverse of this page where the risks are detailed. In addition, I acknowledge the detrimental health effects of the disease. Lastly, I have read and understand the availability and effectiveness of the vaccine.

I do not wish the vaccine and I voluntarily agree to release, discharge, indemnify and hold harmless the State of Maryland, the University, its officers, employees and agents from any and all costs, liabilities, expenses, claims, demands, or causes of action on account of any loss or personal injury that might result from my non-compliance with the law.

To be filled out by student and parent/guardian, if applicable.

I have read and signed this document with full knowledge of its significance. I further state that I am at least 18 years of age and competent to sign this waiver.

Student Signature _____ Date _____

If the student is under age 18, a parent/guardian must sign this waiver.

Signature of Parent/Guardian _____ Date _____

Name of Parent/Guardian (please print) _____