HOWARD UNIVERSITY

Student Health Center

PRE-ADMISSION HEALTH CHECKLIST

Please use this checklist as a guideline for submitting all the health forms we need to remove your medical hold. You are responsible for ensuring that all fields on the forms are completed. Incomplete forms will cause a delay in your ability to register for classes. **ALL students, regardless of age, are required to be screened for Tuberculosis (TB). In addition, in accordance with D.C. Law 3-20, students under the age of 26 by AUGUST 1st (fall semester) and December 1st (spring semester) must provide documentation of vaccination or immunity from Hepatitis B, Diptheria, Tetanus, Measles, Mumps and Rubella and Varicella. Submit your completed packet via fax or drop off.**

DEADLINE FOR FALL IS JULY 1ST AND SPRING IS DECEMBER 1ST

- ❑ **Mandatory Pre-Admission Health Form**
  - ❑ There are two forms included, one for Undergraduate and Graduate school and one for Health Science Schools. Fill the correct form for your school/college .
  - ❑ Did your healthcare provider screen you for tuberculosis? If you do a PPD test, make sure the form lists the date(s) the test was placed AND the date it was read. If you had a blood test, make sure the official lab result is attached to the form. We do not accept handwritten notes.
  - ❑ Make sure all of the immunizations on the form were filled out with the correct dates.
  - ❑ Make sure your healthcare provider prints their name, signs, and dates the form.
  - ❑ If you send immunization documents from another office, be sure the names of the vaccines match what is on our form, and that it is signed or stamped by that office. Tetanus/Diphtheria vaccines are seemingly similar but there is a difference between Td, Dt, Tdap, and DPT vaccines. Make sure you list the right ones!
  - ❑ If you do not have access to your immunization history, you can ask your doctor to draw immunity titers for MMR, Hepatitis B, and Varicella. You still need to satisfy the requirements for Tuberculosis Screening, Tetanus/Diphtheria & acellular Pertussis, and Meningococcal vaccinations (first time in college and/or will live in residence halls).
- ❑ **Medical History form**
- ❑ **Physical Examination form**

ALERT !!! DOES EVERY FORM HAVE YOUR NAME, DATE OF BIRTH, AND STUDENT ID NUMBER?

HEALTH SCIENCE STUDENTS
(Medical, Dental, Pharmacy, Nursing & Allied Health)

In addition to the above checklist, review these extra requirements pertinent to your entry :

- ❑ **Official lab results** documenting immunity to MMR, Hepatitis B, and Varicella. We do not accept handwritten notes.
- ❑ Be sure you have been screened for tuberculosis correctly! You are required to have a **Two Step** PPD. If you elect to test by blood, you need to submit the official lab result with your forms. We do not accept handwritten notes.

Student Health Center
2139 Georgia Ave NW, 2nd floor
Washington, DC 20059

Tel: 202.806.7540
Fax: 202.806.7416
huhealthcare.com/healthcare/students

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Health Sciences :
- ❑ Dentistry
- ❑ Medicine
- ❑ NAHS
- ❑ Pharmacy

Semester :
- ❑ Fall
- ❑ Spring
- ❑ Summer

Year : _____

MANDATORY PRE-ADMISSION HEALTH FORM

ALL HEALTH SCIENCE STUDENTS [MEDICAL, DENTAL, PHARMACY, NURSING, ALLIED HEALTH]

_____ _____ _____

Name (Last, First, Middle) | **Date of Birth (mm/dd/yyyy)** | **Student Identification Number**

To be Completed by Healthcare Provider:

Tuberculosis Screening for ALL HEALTH SCIENCE students. Must be within 6 months before enrollment date.

Option 1: Two Step PPD	**Option 2 : TB BLOOD TEST (TB Gold or TSpot)**	**IF SKIN/BLOOD TEST POSITIVE, OR HISTORY OF POSITIVE TEST:**
Date PPD #1 Placed: ____/____/ ____ Date PPD #1 Read: ____/ ____/ ____ Result: ____mm **2 nd TB test must be 1-3 weeks after 1st test** Date PPD #2 Placed: ____/____/ ____ Date PPD #2 Read: ____/ ____/ ____ Result: ____mm	Date of TB blood test: ____/_____/_____ Result: _____ **Please attach copy of blood test**	Date of Chest X-Ray: ____/ ____/ ____ **ATTACH A COPY OF CHEST X-RAY REPORT** Patient received INH: ____ No ____ Yes Duration of treatment: ____ Months

TETANUS / DIPHTHERIA Tetanus/Diphtheria (Td) within the last 10 years. **Note: MUST HAVE AT LEAST ONE Tdap**	Tdap Dose **(REQUIRED)** ____/____/____ Date of Td Booster ____/____/____
MEASLES / MUMPS / RUBELLA (MMR) Two doses required. History of disease is not acceptable. If you were born before 1957 and are not enrolled in health sciences, you are exempt from the MMR requirement.	Dose (1) ____/____/____ Dose (2) ____/____/____ Booster ____/____/____
HEPATITIS B Three doses required.	Dose (1) ____/____/____ Dose (2) ____/____/____ Dose (3) ____/____/____ Booster (1) ____/____/____ Booster (2) ____/____/____
VARICELLA Two doses required. History of chickenpox is acceptable only when it is documented by a medical provider with month/year of disease.	Dose (1) ____/____/____ Dose (2) ____/____/____ Booster ____/____/____ History of Chickenpox ____/____/____
MENINGOCOCCAL Booster **required** if primary dose given before 16th birthday.	Date of Dose must be after student is 16 years old ____/____/____
For students under the age of 18 at the time of registration, three doses of **POLIO** vaccine required.	Dose (1) ____/____/____ Dose (2) ____/____/____ Dose (3) ____/____/____

IMMUNITY TITERS. Official lab results must be submitted with this form. Written results will not be accepted.

❑ Measles	❑ Mumps	❑ Mumps	❑ Hepatitis B	❑ Varicella

Office Name	**Healthcare Provider Signature**
Office Address	
Office City, State, Zip	**Healthcare Provider Printed Name**
Office Telephone Number	**Today's Date**

In accordance with D.C. Law 3-20, students under age 26years by August 1st for Fall enrollment or January 1st for Spring enrollment are required to provide documentation of vaccination or immunity (lab test, if appropriate) from Diphtheria, Tetanus, Hepatitis B, Measles, Mumps, Rubella and Varicella. Students under 18 years must be vaccinated against polio. This certificate must be returned to the Student Health Center by July 1st for the Fall term or December 1st for the Spring term. In order to avoid delays, please see your healthcare provider as soon as possible to complete this certificate. It is your responsibility to ensure that all appropriate sections of this form are completed. Fax this document to 202-806-7416 or drop the form off at the Student Health Center. Keep a copy for your records, and bring it with you when you come to the health center.

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MEDICAL HISTORY FORM

Section 1 : Demographics (to be completed by student)

LAST NAME **FIRST NAME** **MIDDLE NAME** **DATE OF BIRTH (mo/day/yr)** **STUDENT ID#**

PERMANENT ADDRESS **CITY** **STATE** **ZIP** **PHONE #**

PERSONAL EMAIL **PLACE OF BIRTH** **MARITAL STATUS** **GENDER**

Class you are entering (circle) :	**Semester you are entering (circle) :**
FR SO JR SR OTHER _____	FALL SPRING SUMMER Year _____

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY **RELATIONSHIP**

ADDRESS **CITY** **STATE** **ZIP** **PHONE #**

Section 2 : Personal Medical History (to be completed by student)

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING: PLEASE ANSWER EACH QUESTION

Anemia	Y	N	Diabetes	Y	N	Protein or blood in urine	Y	N
Anorexia / Bulimia	Y	N	Dizziness or fainting	Y	N	Chronic pain (severe/recurrent)	Y	N
Allergies / Hay fever	Y	N	Depression	Y	N	Pneumonia	Y	N
Anxiety	Y	N	Eye problem (not glasses)	Y	N	Rectal disease	Y	N
Asthma	Y	N	Fatigue	Y	N	Rheumatic or Scarlet fever	Y	N
Arthritis	Y	N	High blood pressure	Y	N	Skin disease	Y	N
Alcohol / Substance Use	Y	N	Heart condition	Y	N	Seizures	Y	N
Back or neck injury	Y	N	Headaches (frequent/severe)	Y	N	Sexually Transmitted Infections	Y	N
Broken bone (specify)	Y	N	Head injury (severe)	Y	N	Thyroid disorder	Y	N
Bladder or kidney infection	Y	N	Hearing loss	Y	N	Tuberculosis	Y	N
Blood transfusion	Y	N	Hernia (specify)	Y	N	Testicular problems	Y	N
Chest pain or pressure	Y	N	Intestinal problems	Y	N	Other (specify)	Y	N
Chronic cough	Y	N	Kidney stone	Y	N			
Concussion	Y	N	Learning disorder (specify)	Y	N			
Cancer or tumor	Y	N	Malaria	Y	N			

Describe any conditions or disabilities that would exclude participation in physical education (e.g. swimming):

_____

_____

_____

Please list any drugs, medicines, birth control pills, vitamins, minerals including those prescribed to you and those that are not prescribed.

Name of drug	Reason for taking drug	What is the strength and how often?

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MEDICAL HISTORY FORM (continued)

LAST NAME **FIRST NAME** **MIDDLE NAME** **DATE OF BIRTH (mo/day/yr)** **STUDENT ID#**

Section 2 continued : Personal Medical History (to be completed by student)

Please list allergies below including the type of reaction you experienced, how old you were when it occurred, and if the experience has occurred more than once.

Medications : _____

Foods : _____

Others : _____

	Yes	No	Explanation (specify when, where, and why)
Have you ever been a patient in any type of hospital? Include surgeries, ER visits, overnight stays			
Has your academic career been interrupted due to physical or emotional problems?			
Have you ever had any serious illnesses or injuries other than those already noted?			

Section 3 : Screening (to be completed by student)

1.	Over the past 2 weeks, have you felt down, depressed, or hopeless?	Y	N
2.	Over the past 2 weeks, have you felt little interest or pleasure in doing things?	Y	N
3.	In the past year, have you had significant problems with insomnia, bad dreams, or falling asleep during the day?	Y	N
4.	In the past year, have you thought about ending your life or had thoughts about suicide?	Y	N
5.	In the past year, did you have a hard time paying attention at school, work, or home?	Y	N
6.	Have you ever felt you should cut down on your drinking or drug use?	Y	N
7.	Have you ever taken a drink or a drug first thing in the morning to steady your nerves or get rid of a hangover?	Y	N
8.	For men, have you ever had 5 or more drinks in a day? For women, have you ever had 4 or more drinks in a day?	Y	N
9.	Have you used recreational or prescription drugs to get high?	Y	N
10.	Do you exercise 3 or more times per week?	Y	N
11.	Do you use tobacco? How many packs per day?	Y	N

Section 4 : Family Medical History

Has any person, related to you by blood, had any of the following conditions?

	Yes	No	Relationship		Yes	No	Relationship		Yes	No	Relationship
High blood pressure				Cholesterol disorder				Cancer (type) :			
Stroke				Diabetes				Alcohol/Substance abuse			
Heart attack before age 55				Glaucoma				Psychiatric Illness			
Blood or clotting disorder				Asthma				Suicide			
Other :											

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MEDICAL HISTORY FORM (continued)

LAST NAME **FIRST NAME** **MIDDLE NAME** **DATE OF BIRTH (mo/day/yr)** **STUDENT ID#**

IMPORTANT INFORMATION ….. PLEASE READ AND COMPLETE

STATEMENT BY STUDENT: (A) I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, except in an emergency or by Court Order. However, if I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission for the Student Health Center to release information from my record to a physician, hospital or other medical agency involved in providing me with emergency treatment and/ or medical care. (B) I hereby authorize any medical treatment for myself that may be advised or recommended by the providers of the Student Health Center. (C) Mental Health: I also hereby authorize transportation to Howard University Hospital when recommended by the psychologist/psychiatrist of the University Counseling Center.

Student Signature _____ **Date** _____

PARENTAL/GUARDIAN PERMIT – MUST BE COMPLETED IF STUDENT IS UNDER 18 YEARS OF AGE

The LAW requires that parental permission be obtained for medical treatment of minors. A parent or guardian should sign the following consent form so that medical treatment may be given to the student who is a minor. However, no major operation will be performed except in extreme emergency, without parent/guardian being contacted and fully informed. I give permission for such diagnostic and therapeutic procedures as may be deemed necessary for my daughter/son/ward.

Signature _____ **Relationship** _____ **Date** _____

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Date of Physical _____

PHYSICAL EXAMINATION FORM

LAST NAME **FIRST NAME** **MIDDLE NAME** **DATE OF BIRTH (mo/day/yr)** **STUDENT ID#**

Medical History

Review of Systems:

Respiratory	GU Tract
Cardiovascular	Musculoskeletal
GI Tract	Neurological

PMH	**Allergies**
PSxh	**Medications**
SH	**Immunizations up to date?**

PHQ2 Screening (if positive, complete PHQ9)

Over the past 2 weeks, has the student had little interest or pleasure in doing things? Y N

Over the past 2 weeks, has the student felt down, depressed, or hopeless? Y N

Objective Findings

BP	**P**	**R**	**T**
Height	**Weight**	**BMI**	**LMP**
Vision Uncorrected :	R eye	L eye	Both
Vision Corrected :	R eye	L eye	Both

General Appearance/Mental Status: _____

Check appropriate answer	Normal	Abnormal	Comment on abnormalities
HEENT			
Lungs			
Breasts			
Heart (size, rhythm, murmurs)			
Abdomen (scars, hernia, mass)			
Genitourinary (pelvic in females)			
Anus, Rectum (prostate in males)			
Extremities			
Musculoskeletal			
Skin and lymphatics			
Neurological, reflexes			

Screening Laboratory Data

UA | Date : Protein : Glucose :	**Hgb/Hct** (females only) | Date : Results :

Health Sciences Students : Please refer to the Health Clearance Checklist to see all required labs needed to obtain a Health Clearance Certificate. Depending on your school, labs may include HIV, RPR, stool culture, nasal culture, and urine drug screen.

ASSESSMENT AND RECOMMENDATIONS

RESTRICTED ACTIVITY: **No** □ **Yes** □ **Reason for Restriction:** _____

Provider's Signature and Title: _____ **Date:** _____

Provider's Name and Title: _____ **Office/Clinic Phone No:** _____

HOWARD UNIVERSITY

Student Health Center

FREQUENTLY ASKED QUESTIONS

1. **What is a "medical hold" and why do I have one?**
   Once you have been accepted to Howard University and have paid your enrollment fee, you are automatically placed on "medical hold" until you satisfy the immunization compliance requirements set forth by Howard University Student Health Center policies in conjunction with DC Law 3-20. This is to ensure the safety of the campus community and those you may come in contact with. You will not be able to register for classes until we remove your medical hold.

2. **I do not have shot records. Do I have to take all of the immunizations again?**
   You will need to have your primary care provider order immunity titers for Measles, Mumps, Rubella, Hepatitis B, and Varicella and submit the official lab results to us. We do not accept handwritten notes. If the results show that you are not immune, you will need to begin vaccinations **PRIOR** to your arrival at Howard University. If you are under 18, you need documentation of polio vaccination. Keep in mind that you will still need a Tdap vaccine, meningococcal vaccine, and tuberculosis screening to satisfy entry requirements.

3. **Should I get the vaccines before I arrive?**
   Yes, you are required to have all forms and vaccinations completed **PRIOR** to your arrival at Howard University. You may incur a fee for vaccines given at the Howard University Student Health Center. In addition, incomplete records will delay our ability to lift your medical hold and prevent you from registering for classes.

4. **I am a health professional student. What does it mean to do titers?**
   Titers are a blood draw to demonstrate that you have immunity to the diseases you have been vaccinated against. It could be that after you have gotten the vaccine, your immunity has faded. As a health professional, we need to be certain that we are protected. If you are non-immune to the disease, you will need to be re-vaccinated (called a "booster" dose). Repeat titers should be done at least 6 weeks after a booster shot. Keep in mind that official lab results need to be submitted. Handwritten results will not be accepted.

5. **What are common mistakes made with the Immunization/TB form?**
   a. Form not signed by a provider
   b. Student name is not on the form
   c. PPD date of placement AND date of reading not noted
   d. PPD reading took place >3 days after placement
   e. PPD was performed > 6 months before registration
   f. Measurement of PPD not done (should be read as 0 mm, or 8 mm, etc.)
   g. Two-step PPD not performed correctly for health professional students
   h. Titers not performed for health professional students
   i. No booster doses given when titers are non-immune
   j. No official lab or xray results submitted (ex: no chest x-ray report, no lab forms for titers)
   k. Students do not keep a copy of the immunization form or bring a copy to the health center
   l. It is not clear whether the tetanus shot was a Td or a Tdap (we require at least one Tdap)

6. **How should I return the form?**
   By fax or drop off

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