Bowie State University

Henry Wise Wellness Center
14000 Jericho Park Rd., Bowie, MD 20715-9465

ENTRANCE MEDICAL HISTORY FORM

Mail to the above address or fax to (301)860-4179; Please call (301)860-4170 for questions

DUE: June 1st or 30 days after admission

Incomplete forms will NOT be processed and will delay your registration

Make a copy of these documents for your personal files.

Section A (Required): To be completed by ALL students. Print legibly.

Name (Last) _____ (First) _____ (Middle) _____

Your 1st BSU enrollment (Semester, Year) _____ Last 4 digits of SSN _____ Date of Birth _____

Empl ID # _____ E mail Address _____

Student Status: □U.S. Citizen □ Permanent Resident □ International

Permanent Address _____

Home Phone _____ Cell Phone _____

Emergency Contact _____ Telephone Number _____

Section B (Required): To be completed by ALL students born after 1957.

MMR #1 Date: _____ **and** **MMR #2** Date: _____

OR

MEASLES TITER: Date: _____ Results: _____

Section C (Required): To be completed by ALL students.

Meningitis: Date: _____ (Vaccine/waiver required for students living in dormitories. Commuters are required to sign the waiver. **See reverse for meningitis waiver only.**)

Section D (Recommended): Please record other immunizations you have received.

Tetanus-Diphtheria (Td) (within 10 years) Date: _____

Polio (oral): Date #1_____ Date #2_____ Date #3_____ Date #4_____

Hepatitis B: Date #1_____ Date #2_____ Date #3_____

Varicella (Chicken Pox) Date #1_____ Date #2_____

OR history of disease Date: _____

Section E: Required for international students. Complete sections A, B, C and D.

Tuberculin Skin Test:

a.) T.B Skin Test within 12 months: Date Given: _____ Date Read: _____

Results: **Induration** _____ mm. (if no induration, write "0") □Positive □Negative

b.) **If PPD (TB Skin Test) is positive, a recent Chest x-ray is required (within 5 years, report must be in English).**

Date of chest x-ray: _____ Results: □ Normal □ Abnormal

Section F (Required): Health care provider signature or documentation required for ALL students.

_____

Signature of Health Care Provider **Print Name Here** **Date**

Acceptable documentation in lieu of health care provider signature:

- A copy of your high school immunization record (in English).
- Personal medical records from your physician (in English).

For Staff Only
UID#_____ Semester/Year of Enrollment_____
Chart _____ EMH Hold _____
Initial, Date_____
□MMR □MEN □WAIVER
□Complete □Incomplete □Contacted, Date_____

Section G: Meningitis Vaccine Waiver.

Vaccine or waiver required for All BSU students. See page 1 for vaccine. See below for waiver.

About Meningococcal Vaccine

A Meningococcal Vaccine is available for protection against most strains of the bacteria that causes meningitis. Meningitis is inflammation of the covering of the brain and spinal cord that is fatal in 10 – 15 % of the cases. Although the disease is rare, college students living in dormitories and individuals with weak immune systems can be more susceptible to the disease. The immunization requires one injection in the arm and is 85 – 90 % protective against strains A, C, Y, and W-135, but not type B. Most meningococcal diseases in the U.S. are caused by type B or C.

I understand that under Maryland law, student enrolled in a Maryland institution of higher education and who reside in on-campus student housing are required to be vaccinated against meningococcal meningitis disease, or may seek exemption from this law. I have read the meningitis material 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, which is available possibly from Prince George County Health Department or from my personal physician.

_____I have read about the Meningococcal Disease. I have read and understand the benefits of the vaccine for Meningococcal Meningitis. I **do not wish** to receive 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 loss or personal injury that might result from my non-compliance with the law.

Signature _____ _____ _____

(Parent or guardian must sign for student who is younger than 18.) Print Name Date

Section H (Required): Personal Health History to be completed by ALL students.

Have You Ever Had Or Do You Now Have Any Of The Following:

Yes	No		Yes	No	
☐	☐	Drug allergy (Specify)	☐	☐	Other allergy (Specify)
☐	☐	Hospitalization within 6 months	☐	☐	Disability which requires assistance
☐	☐	Nervous or emotional problems	☐	☐	Travel abroad within last 6 months
☐	☐	Smoke cigarettes or chew tobacco	☐	☐	Use street drugs
☐	☐	Drink alcohol	☐	☐	Asthma
☐	☐	High blood pressure	☐	☐	Diabetes
☐	☐	Seizure disorder	☐	☐	Sickle cell disease or trait
☐	☐	Malaria	☐	☐	Cancer/ Leukemia
☐	☐	Bleeding disorder	☐	☐	Sexually transmitted infections (Specify)

Please explain any yes answers here (include year).

_____

_____

Please list All current medications, including vitamins, birth control pills, nutritional supplements.

_____

_____

Please list any illness, injury, disability, or surgery not mentioned above, include tonsillectomy, appendectomy , and psychiatric treatment or counseling._____

_____

Section I (Required): ALL students or parents / guardians must sign the form.

Student Signature_____ Print Name_____ Date_____

Parental Permit (for students under age 18 on the first day of admission to BSU)

I give my permission for such diagnosis 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 officials when deemed necessary.

Parent / Guardian Signature_____ Relationship_____ Date_____

Print Name_____

- **It is recommended that all students have health insurance; a policy is available through the University.**
- **Failure to submit a completed entrance medical history form will result in registration block for the future semester.**