

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; Call (301)860-4170 for questions

Incomplete forms will NOT be processed and will delay your registration.

Make a copy of these documents for your personal files. Submit ONE COPY only.

Failure to submit a completed EMH form will result in registration blocks.

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 _____

Student ID # _____ Email _____

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 on and after 1957.

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

OR

MEASLES TITER: Date: _____ Results: _____

Section C (Required): To be completed by students living in dormitories.

Meningitis: Date: _____ (If you do not plan to receive the vaccine, please read and sign the waiver on page 2. 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.

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).
- Immunization records from your care provider's office (in English).

For Staff Only	Date Received _____
UID# _____	Semester/Year of Enrollment _____
Chart _____	EMH Hold _____
Initial, Date _____	
<input type="checkbox"/> MMR <input type="checkbox"/> MEN <input type="checkbox"/> WAIVER	
<input type="checkbox"/> Complete <input type="checkbox"/> Incomplete <input type="checkbox"/> Contacted, Date _____	

Section G : Meningitis Vaccine Waiver.

Vaccine or waiver required for All BSU resident 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 |
|--------------------------|---|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Drug allergy (Specify) | <input type="checkbox"/> | <input type="checkbox"/> Other allergy (Specify) |
| <input type="checkbox"/> | <input type="checkbox"/> Hospitalization within 6 months | <input type="checkbox"/> | <input type="checkbox"/> Disability which requires assistance |
| <input type="checkbox"/> | <input type="checkbox"/> Nervous or emotional problems | <input type="checkbox"/> | <input type="checkbox"/> Travel abroad within last 6 months |
| <input type="checkbox"/> | <input type="checkbox"/> Smoke cigarettes or chew tobacco | <input type="checkbox"/> | <input type="checkbox"/> Use street drugs |
| <input type="checkbox"/> | <input type="checkbox"/> Drink alcohol | <input type="checkbox"/> | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> | <input type="checkbox"/> Sickle cell disease or trait |
| <input type="checkbox"/> | <input type="checkbox"/> Malaria | <input type="checkbox"/> | <input type="checkbox"/> Cancer/ Leukemia |
| <input type="checkbox"/> | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> | <input type="checkbox"/> 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. _____ _____
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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.