McDANIEL COLLEGE

The Wellness Center
Winslow Center
2 College Hill
Westminster, MD 21157
Tel: 410-857-2243
Fax: 410-857-2703
wellness@mcdaniel.edu

OFFICE USE ONLY:

Date Received:_____

Method Received:_____

Student ID#:_____

Email: _____

PRE-ENTRANCE STUDENT HEALTH FORM

DUE DATES: **July 1st** (Fall enrollment) **January 15th** (Spring enrollment)

Step 1: Review Immunization Requirements in Part 1 and locate an official copy of student's immunization record. *If student (parent if under 18) has chosen to waive the meningococcal vaccination, the waiver must be signed.*

Step 2: Student completes Part 2: Student Information, Part 3: Medical History, and Part 4: Tuberculosis Screening Questions. *If student is under 18, parent/guardian must sign Consent for Treatment of a Minor in Part 2.*

Step 3: If Student answered YES to any of the Tuberculosis Screening Questions in Part 4, the student's Health Care Provider must complete Part 5: Tuberculosis Clinical Assessment and Testing

Step 4: Submit 1) entire form (both sides); 2) official copy of immunization record; 3) copy of insurance card:

- **Email**: wellness@mcdaniel.edu (attach form as a PDF; **do not** submit photographs of form)
- **Mail or Drop-off:** McDaniel College Wellness Center, 2 College Hill, Westminster, MD 21157
- **Fax**: 410-857-2703 (include cover page with student's full name and date of birth)

Step 5: It is strongly recommended that students contact the Wellness Center to confirm receipt and completion of requirements and keep a copy of all completed forms.

PLEASE READ!

In an effort to maintain a healthy campus community and comply with state law, all full-time undergraduate students are **REQUIRED** to complete this form and return it to the Wellness Center by the **DUE DATE**: **July 1st (Fall) or January 15th (Spring)**.

Failure to submit a complete *Pre-Entrance Student Health Form* with *official copy of immunization record* will result in the following:

- Residential students **will not be able to move into college housing** until they have submitted documentation of receiving the required meningococcal vaccine (after age 16) or signed the waiver. *Students who are under 18 must have parent/guardian sign the waiver.*
- A **non-refundable $500 fine** will be applied to the student's billing account
- Students will **not be eligible to utilize Student Health Services** in the Wellness Center.

Prospective Intercollegiate Athletes: If you are an incoming first-year and/or transfer student who wishes to try out for an intercollegiate sports team at McDaniel, you must complete this Pre-Entrance Student Health Form AND the athletics medical information and forms. The Pre-Entrance Student Health Form is available in your entrance packet and the athletics packet is available at www.mcdanielathletics.com/information/athletic-training/athlete-packet-index. The Pre-Entrance Student Health Form must be returned to the Wellness Center (wellness@mcdaniel.edu) and the athletics packet must be submitted to the Department of Athletics (gnibbeli@mcdaniel.edu).

Full-time Graduate Students: Full-time graduate students are eligible to utilize Student Health Services in the Wellness Center only if they have completed this form.

Special Housing Considerations: Requests for special housing considerations must be directed to the Office of Residence Life at 410-857-2240.

PART 1: IMMUNIZATIONS

You MUST provide an official copy of your immunization record. Official immunization documentation may include: immunization record from health care provider with official stamp, signature, copy of high school immunization record, or International certificate of vaccination (in English).

REQUIRED IMMUNIZATIONS

MMR (Measles, Mumps, Rubella)

- 2 doses of combined MMR vaccines OR 2 doses of each individual vaccine (measles, mumps, and rubella)
  - First dose given after 1st birthday
  - At least 4 weeks between doses
- If documentation of MMR vaccines is unavailable, positive blood tests showing immunity to measles, mumps, and rubella are required
- Persons born before 1957 are considered immune due to natural infection

Tetanus and Diphtheria

- Tdap (Tetanus-Diptheria-Pertussis) or Td (Tetanus- Diptheria) booster within 10 years of enrollment. Tdap is strongly recommended over the Td booster. *DTaP series in childhood is not sufficient.*

Meningococcal (Meningitis)

Maryland law requires all students who reside in on-campus housing at Maryland colleges and universities to be vaccinated against meningococcal disease unless the individual signs a waiver. At McDaniel College, this is required of all undergraduate students, both commuter and residential.

- At least one dose of the 4-valent (ACYW) meningococcal conjugate ***after age 16*** is required.
- If after reviewing the information regarding the risks associated with the disease and availability and effectiveness of the vaccine, the student *(or parent, if student is under age 18)* may sign the waiver below indicating the choice not to be vaccinated.

Meningococcal Vaccine Information and Requirement Waiver

For additional information:https://phpa.health.maryland.gov/OIDEOR/IMMUN/Pages/meningococcal-disease.aspx

What is meningococcal disease?

Meningococcal disease is a rare but life threatening illness, caused by the bacterium, *Neisseria meningitis.* It is a leading cause of bacterial meningitis (an infection of the brain and spinal cord coverings) in the United States. The most severe form of the disease is meningococcemia, infection of the bloodstream by this bacterium. Deaths from meningococcal disease have occurred among Maryland college students in recent years. Students living in dormitories or residence halls are at increased risk. The Maryland Department of Health and Mental Hygiene encourages meningococcal vaccination of higher education students. About 2,600 people get meningococcal disease each year in the U.S. 10-15% of these people die, in spite of treatment with antibiotics. Of those who live, 10% lose their arms or legs, become deaf, have problems with their nervous systems, become mentally retarded, or suffer seizures or strokes.

About the vaccine

Meningococcal vaccine can be effective in preventing four types of meningococcal disease. The vaccine is not effective in preventing all types of the disease, but it does help to protect many people who might become sick if they don't get the vaccine. Drugs such as penicillin can be used to treat meningococcal infection. Still, about one out of every ten people who get the disease dies from it, and many others are affected for life. A vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reaction. People should not get meningococcal vaccine if they have ever had a serious allergic reaction to a previous dose of meningococcal vaccine. Some people who get meningococcal vaccine have mild side effects, such as redness or pain where the shot was given (which is usually under the skin of the upper arm). A small percentage of people who receive the vaccine develop a fever. The vaccine may be given to pregnant women. Meningococcal vaccine is available in some school health centers, travel clinics, some county health departments, and the offices of some health providers.

WAIVER

Individuals 18 years of age and older may sign a written waiver choosing not to be vaccinated against meningococcal disease. For individuals under 18 years of age, the parent or guardian of the individual must review the information on the risks of meningococcal disease and sign a written waiver that he/she has chosen not to have the individual vaccinated against meningococcal disease. *I have received and reviewed the information provided on the risk of meningococcal disease and the effectiveness and availability of meningococcal vaccine. I understand that meningococcal disease is a rare but life threatening illness. I understand that Maryland law requires that an individual enrolled in an institution of higher education in Maryland who resides in on-campus student housing shall receive vaccination against meningococcal disease unless the individual signs a waiver to the vaccination. I choose to waive receipt of meningococcal vaccine.*

_____

Student Signature Print Name Date

_____

Parent/Legal Guardian Signature (If student is under 18) Print Name Date

****

In addition, the following immunizations are Recommended but NOT REQUIRED by McDaniel College:

Varicella (Chicken Pox), Hepatitis A, Hepatitis B, HPV, Polio, Serogroup B Meningococcal

PART 2: STUDENT INFORMATION

Last Name | First Name | Middle Name | Date of Birth: Month / Day / Year

Home Address | City | State | Zip

Cell Phone Number | Home Phone Number | McDaniel Email | Student ID#

Sex Assigned at Birth (Biological Sex): ☐ Male ☐ Female ☐ Intersex

Gender Identity | Preferred Name | Pronouns

Term Entering McDaniel College: ☐ Fall _____ Year ☐ Spring _____ Year

Check all that apply: ☐ Undergraduate ☐ Graduate ☐ Transfer ☐ Commuter ☐ International Student ☐ McDaniel Athlete

IN CASE OF EMERGENCY, NOTIFY

Name | Relationship | Cell Phone Number | Alternate Phone Number

CONSENT FOR TREATMENT OF A MINOR *(Parent/Guardian signature required if student is under 18)*

Maryland law requires surgical and medical treatment of minors and release of medical information to hospitals, physicians, and insurance companies regarding conditions treated by McDaniel College Wellness Center be at the request of and with the approval of their legal guardians. This right to request an approval may be delegated to college officials. It is our policy to notify a student's guardians as soon as possible in the event of major illness or injury; however, it is impractical to do so for every minor illness or injury requiring treatment. It will help us protect the health of your child and expedite their care if you delegate for the college to use discretion in these matters. I give my permission for such diagnostic and therapeutic procedures as may be deemed necessary for my child and agree to present information concerning my child's medical condition to other responsible college officials when deemed desirable. I understand that no major procedure will be performed- except in extreme emergency, without my being contacted and fully informed.

Parent/Legal Guardian Signature (If student is under 18) | Print Name | Date

HEALTH INSURANCE INFORMATION: ***INSURANCE CARD: Please attach a copy of Insurance Card (front and back)***

McDaniel College requires ALL full-time undergraduate students to have health insurance. McDaniel offers students the option of purchasing a comprehensive Student Health Insurance Plan. If you currently have health insurance coverage and would like to waive the option of purchasing the Student Health Insurance Plan, you must waive the policy no later than **August 15th (Fall) or February 15th (Spring)** by completing the waiver found at www.wellfleetstudent.com. If you do not complete the online waiver to provide proof of health insurance coverage by the deadline, you will be automatically enrolled in McDaniel's Student Health Insurance Plan and the charge will be applied to your tuition account. Students will need to waive the insurance each year they are enrolled in McDaniel College. Please review your current plan to be sure your benefits extend to the Maryland area.

Which insurance will you utilize? ☐ Private Health Insurance ☐ McDaniel College Student Health Insurance Policy

Insurance Company | Name of Policy Holder

Policy Number | Group Number

Insurance Company Address

PART 3: MEDICAL HISTORY

ADD/ADHD	□ Current □ Past □ Never	Heart Murmur	□ Current □ Past □ Never
AIDS, ARC, or HIV+	□ Current □ Past □ Never	Hepatitis	□ Current □ Past □ Never
Allergies	□ Current □ Past □ Never	High Blood Pressure	□ Current □ Past □ Never
Anemia	□ Current □ Past □ Never	Hypoglycemia (low blood sugar)	□ Current □ Past □ Never
Anxiety	□ Current □ Past □ Never	Irritable Bowel Disease	□ Current □ Past □ Never
Asthma	□ Current □ Past □ Never	Kidney Disease	□ Current □ Past □ Never
Back Problems	□ Current □ Past □ Never	Migraines	□ Current □ Past □ Never
Bleeding Disorder	□ Current □ Past □ Never	Mononucleosis	□ Current □ Past □ Never
Bronchitis	□ Current □ Past □ Never	Neck Injury	□ Current □ Past □ Never
Cancer	□ Current □ Past □ Never	Obesity	□ Current □ Past □ Never
Celiac Disease	□ Current □ Past □ Never	Peptic Ulcer	□ Current □ Past □ Never
Concussion/Head Injury	□ Current □ Past □ Never	Pneumonia	□ Current □ Past □ Never
Depression	□ Current □ Past □ Never	Rash/Hives	□ Current □ Past □ Never
Diabetes	□ Current □ Past □ Never	Rheumatic Fever	□ Current □ Past □ Never
Eating Disorder	□ Current □ Past □ Never	Sickle Cell	□ Current □ Past □ Never
Epilepsy/Seizures	□ Current □ Past □ Never	Sinus Problems	□ Current □ Past □ Never
Fainting/Dizziness	□ Current □ Past □ Never	Skin Disorder	□ Current □ Past □ Never
Fractures/Dislocations	□ Current □ Past □ Never	Smoking Cigarettes	□ Current □ Past □ Never
Gallbladder Disease	□ Current □ Past □ Never	Substance Use Disorder	□ Current □ Past □ Never
GYN/Menstrual Problems	□ Current □ Past □ Never	Thyroid Disorder	□ Current □ Past □ Never
Hearing Loss/deafness	□ Current □ Past □ Never	Tuberculosis	□ Current □ Past □ Never
Heart Problems	□ Current □ Past □ Never	Vision Problems	□ Current □ Past □ Never

Details:

_____

_____

_____

Major Injuries, Surgeries, and Hospitalizations: *Please include approximate year*

_____

_____

_____

Allergies:

Are you allergic to any medications/drugs? □ Yes □ No

Which medication/drug and what is your reaction?_____

Are you allergic to any foods? □ Yes □ No

Which foods and what is your reaction?_____

Do you have any other allergies? (e.g. bee stings, dust, pollen, latex, animal dander) □ Yes □ No

Which allergens and what is your reaction?_____

Do you have an EpiPen? □ Yes □ No

Medications: *Please list all medications you are taking regularly, including prescribed, over-the-counter, and herbal/natural supplements.*

Medication:_____ Dose: _____ Medication:_____ Dose: _____

Medication:_____ Dose: _____ Medication:_____ Dose: _____

Medication:_____ Dose: _____ Medication:_____ Dose: _____

PART 4: TUBERCULOSIS SCREENING QUESTIONS
(To be completed by Student)

1. Have you ever had close contact with persons known or suspected of having active tuberculosis (TB)?	☐ Yes ☐ No
2. Have you ever spent 4 consecutive weeks or longer in any of the following countries with a high incidence of tuberculosis as currently defined by the World Health Organization? **Angola, Bangladesh, Brazil, Cambodia, China, Congo, Central African Republic, DPR Korea, DR Congo, Ethiopia, India, Indonesia, Kenya, Lesotho, Liberia, Mozambique, Myanmar, Namibia, Nigeria, Pakistan, Papua New Guinea, Philippines, Russian Federation, Sierra Leone, South Africa, Thailand, the United Republic of Tanzania, Viet Nam, Zambia and Zimbabwe.** If **Yes**, please list countries and dates: _____ _____	☐ Yes ☐ No
3. Have you been a resident and/or employee of high risk congregate settings (e.g. correctional facilities, long-term care facilities or nursing homes, homeless shelters)?	☐ Yes ☐ No
4. Have you been a volunteer or health care worker who served clients at increased risk for active TB disease?	☐ Yes ☐ No
5. Have you ever been a member of the following groups that may have an increased incidence of latent tuberculosis infection or disease: medically underserved, low-income, or abusing drugs or alcohol?	☐ Yes ☐ No
6. Are you registered at McDaniel as an International Student?	☐ Yes ☐ No

REQUIRED STUDENT SIGNATURE: *I attest that I have answered the above Tuberculosis Screening Questions honestly.*

_____

Student Signature Print Name Date

If you answered YES to any of the above Tuberculosis Screening Questions, McDaniel College requires that your health care provider complete Part 5: Tuberculosis Testing and Clinical Assessment located on the next page of this form. If you answered **NO** to all above questions, Part 5 is not required.

PART 5: TUBERCULOSIS CLINICAL ASSESSMENT AND TESTING
(To be completed by health care provider)

Tuberculosis (TB) Symptom Check

Does the student have signs or symptoms of active pulmonary tuberculosis disease? ☐ Yes ☐ No

If Yes, check all that apply:

- ❑ Cough (especially if lasting for 3 weeks or longer) with or without sputum production
- ❑ Coughing up blood (hemoptysis)
- ❑ Chest pain
- ❑ Loss of appetite
- ❑ Unexplained weight loss
- ❑ Night sweats
- ❑ Fever

Tuberculin Skin Test (PPD)

Date Given	Date Read	Result	Interpretation
____/____/____ Mo Day Year	____/____/____ Mo Day Year	_____ mm induration	☐ Positive ☐ Negative

Blood Test *(preferred if you have received the BCG vaccine)*

Date of test	Type of test administered	Result
____/____/____ Mo Day Year	☐ Quantiferon Gold ☐ T-Spot	☐ Positive ☐ Negative

If PPD > 10 mm induration or blood test is positive, a Chest X-Ray is required

Date of Chest X-Ray	Date of Result	Result
____/____/____ Mo Day Year	____/____/____ Mo Day Year	☐ Normal ☐ Abnormal

Treatment for Latent Tuberculosis

Patient completed full course of treatment for latent TB ☐ Yes ☐ No If No, please give reason:	Start Date: ____/____/____ Mo Day Year Stop Date: ____/____/____ Mo Day Year	Medication: _____

Health Care Provider Signature and Information: By signing below, I attest that I have completed the Tuberculosis Clinical Assessment and Testing

_____ _____ _____

Health Care Provider Signature | Print Name and Title (MD/NP/PA) | Date

_____ _____ _____

Address | Phone Number | Fax Number

******All International Students on Visas***:*** You are required to have a Tuberculosis blood test (QuantiFeron Gold or T-spot) performed in the U.S. within 6 months of entering McDaniel. If you have not completed this blood test by the time you arrive at McDaniel, you must contact The Wellness Center to schedule the test.