

PRE-ENTRANCE STUDENT HEALTH FORM 2022-2023

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 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

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

COVID-19 (SARS-CoV-2): All students must be “Up to Date” on COVID-19 vaccination as described by the Centers for Disease Control and Prevention (CDC): <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html>.

- This means receiving all doses of primary vaccine and recommended booster dose(s) when eligible.
- COVID-19 vaccine must be approved for use in the United States (e.g. Pfizer, Moderna, Johnson & Johnson).

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-Diphtheria-Pertussis) or Td (Tetanus- Diphtheria) 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 the availability and effectiveness of the vaccine, the student (*or parent, if student is under 18*) may sign the waiver below.

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

Revised 2/23/22

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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): <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex																							
Gender Identity				Preferred Name				Pronouns															
Term Entering McDaniel College: <input type="checkbox"/> Fall ____ Year												<input type="checkbox"/> Spring ____ Year											
Check all that apply: <input type="checkbox"/> First Year Student <input type="checkbox"/> Transfer <input type="checkbox"/> Commuter <input type="checkbox"/> International Student <input type="checkbox"/> McDaniel Athlete																							

IN CASE OF EMERGENCY, NOTIFY

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

Special Housing Considerations: Requests for special housing considerations related to health conditions must be directed to the Office of Residence Life at reslife@mcdaniel.edu or 410-857-2240.

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)?	<input type="checkbox"/> Yes <input type="checkbox"/> 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, China, Congo, Central African Republic, DPR Korea, DR Congo, Ethiopia, Gabon, India, Indonesia, Kenya, Lesotho, Liberia, Mongolia, Mozambique, Myanmar, Namibia, Nigeria, Pakistan, Papua New Guinea, Philippines, Sierra Leone, South Africa, Thailand, Uganda, the United Republic of Tanzania, Viet Nam, Zambia. If Yes , please list countries and dates: _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> 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)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you been a volunteer or health care worker who served clients at increased risk for active TB disease?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Are you registered at McDaniel as an International Student?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 if needed)

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	<input type="checkbox"/> Positive <input type="checkbox"/> Negative

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

Date of test	Type of test administered	Result
____/____/____ Mo Day Year	<input type="checkbox"/> Quantiferon Gold <input type="checkbox"/> T-Spot	<input type="checkbox"/> Positive <input type="checkbox"/> 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	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal

Treatment for Latent Tuberculosis

Patient completed full course of treatment for latent TB <input type="checkbox"/> Yes <input type="checkbox"/> No If No, please give reason:	Start Date: ____/____/____ Mo Day Year Stop Date: ____/____/____ Mo Day Year	Medication: _____
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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.