



ADMISSION HEALTH RECORD

and Required Immunizations for NON-HEALTHCARE STUDENTS

REQUIRED FOR ALL FULL-TIME AND HALF-TIME STUDENTS (DISTANCE LEARNERS COMPLETE THIS PAGE ONLY)

Important Notes – Please read prior to completing this form.

- 1. Student should complete PARTS I, III, IV, and V of this form. If under 18, complete PART VI with parent.
2. Proof of immunization may be provided by the following:
- Have your healthcare professional complete "PART II: REQUIRED IMMUNIZATIONS" (page 2). This page must be signed and dated by the healthcare professional to be valid.
- Submit copies of your immunization record from your physician, former high school or university or other official record such as immigration paperwork. If laboratory titers are completed, copies of the lab result must be submitted. Submission of "PART II: REQUIRED IMMUNIZATIONS" is not required if you are submitting copies of records.
3. DEADLINES: This form and proof of immunizations should be submitted to the Evanston campus Health Service by:

Table with 2 columns: Student category and Deadline. Categories include Undergraduate and Graduate students, and All Half-time students. Deadlines range from specific dates to 30 days after acceptance.

- 4. Mail to: Northwestern University Health Service, Health Information Management Services, 633 Emerson St., Evanston, IL 60208
5. STUDENTS WHO FAIL TO SUBMIT THE COMPLETED ADMISSION HEALTH RECORD, INCLUDING PROOF OF IMMUNIZATIONS OR FAIL TO RECTIFY DEFICIENCIES WITHIN 30 DAYS AFTER THE START OF CLASSES WILL BE:
- ASSESSED A NON-REFUNDABLE \$100 LATE FEE AND
- IN ACCORDANCE WITH ILLINOIS STATE LAW, BARRED FROM CLASS REGISTRATION FOR SUBSEQUENT TERMS UNTIL COMPLIANT.
6. For more information about Entrance Health Requirements, visit the Health Service website at: http://www.nuhs.northwestern.edu/evanston/default.aspx.

PART I: Student Information (Please print or type.)

Form fields for student information including Last name, First name, Middle, Gender, Street Address, City, State/Country, Postal Code, Phone number, Date of Birth, and Student ID Number. Includes an email address instruction.

Form fields for enrollment details including First Term attending and year of enrollment, When were you accepted to Northwestern University, Will you be attending Northwestern University on a Student VISA?, and Were you ever previously enrolled at Northwestern University Full-time? Includes maiden name field.

Form section for academic program and immunization requirements. Includes fields for Undergraduate/Graduate program, Distance Learner status, and a note for graduate medical programs.

Northwestern University
PART II: REQUIRED IMMUNIZATIONS
REGULAR FULL-TIME/HALF-TIME STUDENTS (NON-HEALTHCARE PROGRAM)

All full-time and half-time students are required by Northwestern and by Illinois law to submit proof of immunity/vaccination. **THIS SECTION MUST BE COMPLETED BY A HEALTHCARE PROVIDER (e.g. M.D., D.O., or Licensed Nurse).** The provider must provide their name (printed), phone number, and signature/date for this form to be considered valid under Illinois State Law. All records must be submitted in English. A translation by a certified translator with copies of the original records is acceptable. Dates of vaccinations are required.

Student Name: _____ Student ID: _____ DOB: _____

STUDENTS BORN PRIOR TO 1/1/1957 ARE NOT REQUIRED TO SUBMIT IMMUNIZATION RECORDS (If born prior to 1/1/57, you must enclose a copy of your driver's license with page 1 of this form).

M-M-R (COMBINED Measles, Mumps, Rubella) vaccination (2 doses required). <ul style="list-style-type: none"> • If given separately, complete section below instead. 	Dose #1 (after 1 st birthday AND after 1/1/68): ____/____/_____ <hr/> Dose #2 (at least 28 days after dose #1): ____/____/_____ <hr/>
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<p style="text-align: center;">MEASLES (Rubeola)</p> <p>2 doses required. Both must be done after 1st birthday, after 1/1/68, and at least 28 days apart.</p> <p>Dose #1: ____/____/_____ Dose #2: ____/____/_____ OR - Date of illness: ____/____/_____ OR - Attach copy of lab report (titer) confirming immunity (antibodies).</p>	<p style="text-align: center;">MUMPS</p> <p>1 dose required after 1st birthday and 1/1/68.</p> <p>Dose: ____/____/_____ OR - Date of illness: ____/____/_____ OR - Attach copy of lab report (titer) confirming immunity (antibodies).</p>	<p style="text-align: center;">RUBELLA (German Measles)</p> <p>1 dose required after 1st birthday and 1/1/69.</p> <p>Dose: ____/____/_____ OR - Attach copy of lab report (titer) confirming immunity (antibodies). *Date of illness not accepted for Rubella.</p>
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<p>TETANUS/DIPHTHERIA BOOSTER (Td, DT, DTP, DTaP or Tdap meet the requirement.) <ul style="list-style-type: none"> • Must be within <u>10 years</u> prior to entrance into University. INTERNATIONAL STUDENTS (attending University on Student VISA): Booster must be done at least 6 months after last primary series vaccination.</p>	<p>Dose: ____/____/_____ <hr/> Dose: ____/____/_____</p>
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<p>TETANUS/DIPHTHERIA SERIES - REQUIRED ONLY FOR INTERNATIONAL STUDENTS (Those attending Northwestern on Student VISA) <ul style="list-style-type: none"> • MUST list at least 2 dates from primary series (usually done in childhood). • Doses must be at least 28 days apart. </p>	<p>Dose: ____/____/_____ <hr/> Dose: ____/____/_____</p>
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<p>TUBERCULOSIS SCREENING (Not required for half-time students): Answer all of the questions in the Tuberculosis Self-Screening on the following page (PART III). If it is determined that you need a TB test, complete ONE of the following:</p> <ul style="list-style-type: none"> • TB skin test (PPD): Provider <u>must supply dates and result</u> (to the right). • QuantiFERON® TB Gold blood test: A copy of the lab report must be attached. <p>*Testing must be performed in USA and within 6 months of entrance into the University. If test is positive (>=10mm PPD or positive QuantiFERON®) a report from a chest x-ray done in the USA and within 6 months prior to entrance into Northwestern must be attached AND you will be required to meet with a Health Service Physician.</p> <p>*STUDENTS ARRIVING FROM OTHER COUNTRIES in need of a TB test and/or Chest X-Ray have until 30 days after the start of classes to complete without incurring penalty. Please call the Health Service at 847-491-2204 to schedule an appointment <u>after arriving on campus</u>.</p>	<p style="text-align: center;">Required if PPD performed</p> <p>Placed: ____/____/_____ Read: ____/____/_____ Result: _____ (millimeters)</p> <p><small>*If result is >= 10mm, a chest x-ray must be performed in the USA and within 6 months prior to entrance into the University (attach report).</small></p>
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STUDENTS WHO USE THE CHICAGO CAMPUS HEALTH SERVICE TO RECEIVE A VACCINE OR TEST TO FULFILL HEALTH REQUIREMENTS MUST SUBMIT DOCUMENTATION TO THE EVANSTON CAMPUS HEALTH SERVICE! Failure to do so will result in a registration hold.

Healthcare Provider: By signing below, you attest that all information supplied in this section is true and correct to the best of your knowledge.

Name and title of Provider (printed): _____
Signature of Provider: _____ **Date:** ____/____/_____
Phone Number: (_____) _____

Address

Exemptions: If you feel that you are exempt from vaccination requirements based on a medical contraindication, religious belief, or pregnancy, please contact Health Information Management Services at the Northwestern Health Service at 847-491-2203 to discuss the necessary procedures and documentation.

PART III: TUBERCULOSIS SELF-SCREENING (completed by student)

-- THIS IS NOT REQUIRED FOR HALF-TIME OR KELLOGG EMP STUDENTS --

Student Name: _____ Student ID: _____ Birthdate: _____

This screening is **REQUIRED** for all full-time Northwestern students or previously enrolled students starting a new academic program at Northwestern. **Answer questions carefully and appropriately, following the instructions within each question, based on your response.** Information on this form is kept strictly confidential.

Carefully answer all of the following questions (Circle “YES” or “NO”) and follow the appropriate instructions:

1. Do you currently have any of the following unexplained or undiagnosed symptoms: Fever, weight loss, swollen lymph nodes, night sweats, cough for greater than 1 month?: If “YES”, contact your healthcare provider immediately. Follow instruction set “B” below. If “NO”, proceed to next question.	YES	NO
2. Have you ever been diagnosed with tuberculosis? If “YES”, STOP HERE and follow instruction set “A” below. If “NO”, proceed to next question.	YES	NO
3. Have you ever had a positive skin test (PPD) or positive QuantiFERON® TB Gold blood test for exposure to tuberculosis? If “YES”, STOP HERE and follow instruction set “A” below. If “NO”, proceed to next question.	YES	NO
4. In the last 5 years have you lived or traveled <u>OUTSIDE</u> any of the countries listed below for a period longer than 1 month? If “YES”, STOP HERE and follow instruction set “B” below. If “NO”, proceed to next question.	YES	NO
American Samoa, Australia, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Jamaica, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, New Zealand, Norway, St. Kitts and Nevis, St. Lucia, San Marino, Sweden, Switzerland, United Kingdom, United States, U.S. Virgin Islands.		
5. Do you currently have one or more of the following medical conditions listed below? If “YES”, STOP HERE and follow instruction set “B” below. If “NO”, proceed to next question.	YES	NO
Diabetes Silicosis Chronic kidney failure Leukemia or lymphoma IV Drug Use	Cancer of the head, neck, or lung Low body weight (10% or more below ideal) Gastrectomy Jejunioileal (intestinal) bypass	Chronic malabsorption syndromes (i.e. Crohn's or ulcerative colitis) Prolonged corticosteroid therapy (e.g. Prednisone 15mg/daily or more for 1 month)
6. Have you worked, lived, or volunteered in a hospital, homeless shelter, prison, nursing homes, or HIV/AIDS clinic in a capacity where you had contact with patients/residents within the last 5 years ? If “YES”, STOP HERE and follow instruction set “B” below. If “NO”, proceed to next question.	YES	NO
7. Have you had close contact with someone with active tuberculosis or a medically underserved population which is at high-risk for tuberculosis? If “YES”, follow instruction set “B” below.	YES	NO

INSTRUCTIONS (for responses above)

IF YOU ANSWERED “NO” TO QUESTIONS 1-7 ABOVE, YOUR TUBERCULOSIS REQUIREMENT IS COMPLETE.

SET A: You are required to 1) submit a report from a **Chest X-Ray** done in the USA, and within 6 months prior to matriculation into Northwestern and a **copy of your treatment, including medications and dates of treatment** to the Evanston Campus Health Service, and 2) **meet with a Health Service physician** upon arrival to campus (once registered).

SET B: You are required to submit **proof of a TB test** that was 1) performed **in the USA**, and 2) performed **within 6 months prior to entrance** into Northwestern. Acceptable TB tests include a PPD skin test or a QuantiFERON® TB Gold blood test. You must submit either the PPD (including date placed, date read, results in mm induration, with a healthcare provider's signature), or a copy of the QuantiFERON® TB Gold blood test report. If either is positive (PPD \geq 10mm or positive blood test), you are required to follow instruction **SET A** above.

***STUDENTS ARRIVING FROM OTHER COUNTRIES in need of a TB test and/or Chest X-Ray have until 30 days after the start of classes to complete without incurring penalty.** Please call the Health Service at 847-491-2204 to schedule an appointment after arriving on campus.

PART IV: HEALTH HISTORY

REQUIRED FOR STUDENTS INTENDING TO USE THE EVANSTON CAMPUS HEALTH SERVICE FOR THEIR HEALTHCARE NEEDS

Student Name: _____ Student ID: _____ Birthdate: _____

Personal Health History

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY, PROVIDING SPECIFIC DETAILS TO THE BEST OF YOUR KNOWLEDGE.

√	ITEM	DETAILS (list specific information)
<input type="checkbox"/>	Allergies (any)	
<input type="checkbox"/>	Adverse Medication Reaction	
<input type="checkbox"/>	Current medications (prescription or other) If so, list frequency and length of time taken.	

ITEM	√	YEAR	Check each item:	√	YEAR
Alcohol or drug problems	<input type="checkbox"/>		Fractures/Broken Bones	<input type="checkbox"/>	
Appendectomy	<input type="checkbox"/>		Heart condition, disease, or murmur	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>		HIV test Positive or AIDS	<input type="checkbox"/>	
Attention Deficit/Hyperactivity Dis.	<input type="checkbox"/>		High Blood Pressure	<input type="checkbox"/>	
Cancer, leukemia, or lymphoma	<input type="checkbox"/>		Migraine Headaches	<input type="checkbox"/>	
Chicken Pox/Varicella	<input type="checkbox"/>		Mononucleosis/Epstein-Barr Virus	<input type="checkbox"/>	
Cholesterol or lipid problems	<input type="checkbox"/>		Radiation treatment to head/neck	<input type="checkbox"/>	
Depression or Anxiety (specify)	<input type="checkbox"/>		Sexually Transmitted Diseases	<input type="checkbox"/>	
Diabetes Mellitus	<input type="checkbox"/>		Splenectomy	<input type="checkbox"/>	
Eating Disorder/Anorexia/Bulimia	<input type="checkbox"/>		Tonsillectomy	<input type="checkbox"/>	
Emotional/Psychological problems	<input type="checkbox"/>		Transfusion of blood/blood product	<input type="checkbox"/>	
Epilepsy/Seizure Disorder	<input type="checkbox"/>		Viral Hepatitis (specify—A, B, C,?)	<input type="checkbox"/>	

Other surgical/medical condition not listed: _____

Family Health History

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY. Indicate relationship **F**=Father, **M**=Mother, **B**=Brother, **S**=Sister

ITEM	√	Relationship	ITEM	√	Relationship
Alcohol or drug problems/abuse	<input type="checkbox"/>		High Blood Pressure	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>		Kidney Disease	<input type="checkbox"/>	
Cancer, leukemia, or lymphoma	<input type="checkbox"/>		Migraine	<input type="checkbox"/>	
Cholesterol or lipid problems	<input type="checkbox"/>		Stroke	<input type="checkbox"/>	
Diabetes Mellitus	<input type="checkbox"/>		Sudden death under age 50	<input type="checkbox"/>	
Emotional/Psychological problems	<input type="checkbox"/>		Tuberculosis	<input type="checkbox"/>	
Heart attack, disease, or problem	<input type="checkbox"/>		Other—please specify	<input type="checkbox"/>	

PART V: STUDENT SIGNATURE (REQUIRED)

Please sign and date below. By signing you are certifying that all information supplied is correct to the best of your knowledge.

Signature _____

Date _____

PART VI: TREATMENT/SHARING OF MEDICAL INFORMATION OF MINORS (UNDER AGE 18 YEARS)

As the parent/guardian of my minor (under 18 years of age) son or daughter, I hereby authorize:

- 1) The sharing/exchange of relevant medical information between Northwestern University representatives (officials, faculty, staff), Northwestern University Health Service, and, for the purpose of diagnosis and/or treatment, other medical providers. Each of the above individuals or entities is also authorized to communicate and discuss health matters with the parents/guardians/emergency contacts of my minor child.
- 2) The transportation of my minor child, under appropriate circumstances, to area hospitals for diagnosis and treatment.
- 3) The provision, by the Northwestern University Health Service, of such diagnostic, therapeutic, voluntary immunization, and operative procedures as may be deemed necessary for my minor child.

Any and all related expenses will be the responsibility of the student and/or parent/guardian.

Student's Signature : _____ Date: _____

Signature of parent/guardian : _____ Relationship: _____ Date: _____