

Instructions: This form is a requirement for entry to Hope College and Treatment in the Health Center.

1. Complete top boxes. Submit a copy of your immunization record ...**OR**...have your health care provider complete immunization history form below.
2. Backside is to be completed **and signed** by the Hope student.
3. Return form by mail to Hope Health Services, at the above address, **BEFORE** January 9, 2012.
4. **NOTE: All information is confidential and not part of academic records.** The information is only accessible to the staff of the Health & Counseling Services, unless written authorization is provided in compliance with HIPAA.

Last Name	First Name	M.I.
Home Street Address		
City	State	Zip Code

AGE	Birthdate	M / F
Student's Cell Phone Number with area code		
Student's Home Phone Number with area code		
County of Residence if Michigan Resident		

REQUIRED FOR ENTRANCE TO HOPE COLLEGE

<p><u>Tetanus-Diphtheria-Pertussis</u></p> <p>Number of doses provided before age 18?</p> <p>_____</p> <p>Date of last Tdap booster:</p> <p>_____ (mm/dd/yy)</p> <p>One dose Tdap required on or after age 10</p>	<p><u>Polio</u></p> <p>Number of doses given in primary series?</p> <p>_____</p> <p>Last dose given on</p> <p>_____ (mm/dd/yy)</p>	<p><u>Measles-Mumps-Rubella</u></p> <p>2 doses required</p> <p>Dose #1</p> <p>_____ (mm/dd/yy) On or after the first birthday</p> <p>Dose #2</p> <p>_____ (mm/dd/yy) → OR</p> <p>Submission of antibody titres showing immunity is acceptable in lieu of vaccines.</p>	<p><u>Hepatitis B</u></p> <p>3 doses required</p> <p>Dose #1</p> <p>_____ (mm/dd/yy)</p> <p>Dose #2</p> <p>_____ (mm/dd/yy)</p> <p>Dose #3</p> <p>_____ (mm/dd/yy) → OR</p> <p>Submission of antibody titres showing immunity is acceptable in lieu of vaccines.</p>	<p><u>Meningococcal Conjugate Vaccine (MCV4)</u></p> <p>One dose given on or after age 16 is required.</p> <p>Date Given:</p> <p>_____ (mm/dd/yy) Age _____</p> <p>Dose #2 (Required only if first dose before age 16)</p> <p>_____ (mm/dd/yy) Age _____</p>	<p><u>Chickenpox (Varicella)</u></p> <p>MUST HAVE ONE</p> <p>History of disease? I Had disease:</p> <p>_____ (mm/yyyy) → OR</p> <p>Varicella Vaccine Dose #1</p> <p>_____ (mm/dd/yy)</p> <p>Dose #2</p> <p>_____ (mmdd/yy) → OR</p> <p>Submission of antibody titres showing immunity is acceptable.</p>	<p><u>TUBERCULOSIS SELF-SCREENING SUMMARY</u></p> <p>One or more answers on screening tool are YES: TB testing is required.</p> <p>TB skin test results: Date given: _____ Date read: _____ Results mm _____ Positive Negative</p> <p>All answers on screening tool are NO: TB testing is <u>not</u> required. Return TB screening tool with this form.</p>
		<p>_____</p>				

OPTIONAL & TRAVEL RELATED

<p><u>Hepatitis A</u></p> <p>Dose #1</p> <p>_____</p> <p>Dose #2</p> <p>_____</p>	<p><u>HPV</u></p> <p>Dose #1 _____</p> <p>Dose #2 _____</p> <p>Dose #3 _____</p>	<p><u>Typhoid</u></p> <p>Dose #1 _____ INJEC. or ORAL?</p> <p>Dose #2 _____ INJEC or ORAL?</p>	<p><u>Yellow Fever</u></p> <p>Dose #1</p> <p>_____</p> <p>Dose #2</p> <p>_____</p>	<p><u>Influenza vaccine provided at Hope</u></p> <p>Date _____ Type _____</p> <p>Date _____ Type _____</p> <p>Date _____ Type _____</p> <p>Date _____ Type _____</p>	<p><u>TB Testing provided at Hope</u></p> <p>Admin date _____ Result date _____ Result _____</p> <p>Admin date _____ Result date _____ Result _____</p> <p>Admin date _____ Result date _____ Result _____</p> <p>Admin date _____ Result date _____ Result _____</p>
<p><u>Other Vaccines (Do Not Include HIB):</u></p> <p>_____</p> <p>_____</p> <p>_____</p>					

PERSONAL & FAMILY HEALTH HISTORY

<p>Height: _____ Weight: _____</p> <p>Medication Allergies (list):</p> <p>Medications taken regularly:</p> <p>Hospitalizations/Surgeries (with dates):</p> <p>Environmental/Food Allergies:</p> <p>Allergy to Insect bites? yes no</p>	<p style="text-align: right;">* Mark all that apply</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%;"></th> <th style="width: 15%; text-align: center;">Myself</th> <th style="width: 15%; text-align: center;">Family History</th> </tr> </thead> <tbody> <tr> <td>AutoImmune Disorders</td> <td></td> <td></td> </tr> <tr> <td> Diabetes _____</td> <td></td> <td></td> </tr> <tr> <td> Multiple Sclerosis _____</td> <td></td> <td></td> </tr> <tr> <td> Systemic Lupus _____</td> <td></td> <td></td> </tr> <tr> <td> Other: _____</td> <td></td> <td></td> </tr> <tr> <td>Blood Disorders</td> <td></td> <td></td> </tr> <tr> <td> Anemia _____</td> <td></td> <td></td> </tr> <tr> <td> Clotting Deficiency _____</td> <td></td> <td></td> </tr> <tr> <td> Other: _____</td> <td></td> <td></td> </tr> <tr> <td>Cancer</td> <td></td> <td></td> </tr> <tr> <td> Specify: _____</td> <td></td> <td></td> </tr> <tr> <td>Cardio/Pulmonary Disorders</td> <td></td> <td></td> </tr> <tr> <td> Asthma _____</td> <td></td> <td></td> </tr> <tr> <td> Blood Clots _____</td> <td></td> <td></td> </tr> <tr> <td> Heart Murmur _____</td> <td></td> <td></td> </tr> <tr> <td> Heart Disease _____</td> <td></td> <td></td> </tr> <tr> <td> High Blood Pressure _____</td> <td></td> <td></td> </tr> <tr> <td> High Cholesterol _____</td> <td></td> <td></td> </tr> <tr> <td> Other: _____</td> <td></td> <td></td> </tr> <tr> <td>Digestive Disorders</td> <td></td> <td></td> </tr> <tr> <td> Crohn's Disease _____</td> <td></td> <td></td> </tr> <tr> <td> GERD _____</td> <td></td> <td></td> </tr> <tr> <td> Peptic Ulcer _____</td> <td></td> <td></td> </tr> <tr> <td> Irritable Bowel Syndrome _____</td> <td></td> <td></td> </tr> <tr> <td> Other: _____</td> <td></td> <td></td> </tr> <tr> <td>Eating Disorders</td> <td></td> <td></td> </tr> <tr> <td> Anorexia Nervosa _____</td> <td></td> <td></td> </tr> <tr> <td> Binge Eating _____</td> <td></td> <td></td> </tr> <tr> <td> Bulimia _____</td> <td></td> <td></td> </tr> <tr> <td> Other: _____</td> <td></td> <td></td> </tr> <tr> <td>Mental/Emotional Disorders</td> <td></td> <td></td> </tr> <tr> <td> Anxiety _____</td> <td></td> <td></td> </tr> <tr> <td> Depression _____</td> <td></td> <td></td> </tr> <tr> <td> Suicide Attempt _____</td> <td></td> <td></td> </tr> <tr> <td> Other: _____</td> <td></td> <td></td> </tr> <tr> <td>Neurological Disorders</td> <td></td> <td></td> </tr> <tr> <td> ADD/ADHD _____</td> <td></td> <td></td> </tr> <tr> <td> Cerebral Palsy _____</td> <td></td> <td></td> </tr> <tr> <td> Migraine Headaches _____</td> <td></td> <td></td> </tr> <tr> <td> Seizures _____</td> <td></td> <td></td> </tr> <tr> <td> Other: _____</td> <td></td> <td></td> </tr> <tr> <td>Reproductive Health</td> <td></td> <td></td> </tr> <tr> <td> Amenorrhea/Dysmenorrhea _____</td> <td></td> <td></td> </tr> <tr> <td> Ovarian cysts _____</td> <td></td> <td></td> </tr> <tr> <td> Sexually Transmitted Infections _____</td> <td></td> <td></td> </tr> <tr> <td>Other:</td> <td></td> <td></td> </tr> </tbody> </table>		Myself	Family History	AutoImmune Disorders			Diabetes _____			Multiple Sclerosis _____			Systemic Lupus _____			Other: _____			Blood Disorders			Anemia _____			Clotting Deficiency _____			Other: _____			Cancer			Specify: _____			Cardio/Pulmonary Disorders			Asthma _____			Blood Clots _____			Heart Murmur _____			Heart Disease _____			High Blood Pressure _____			High Cholesterol _____			Other: _____			Digestive Disorders			Crohn's Disease _____			GERD _____			Peptic Ulcer _____			Irritable Bowel Syndrome _____			Other: _____			Eating Disorders			Anorexia Nervosa _____			Binge Eating _____			Bulimia _____			Other: _____			Mental/Emotional Disorders			Anxiety _____			Depression _____			Suicide Attempt _____			Other: _____			Neurological Disorders			ADD/ADHD _____			Cerebral Palsy _____			Migraine Headaches _____			Seizures _____			Other: _____			Reproductive Health			Amenorrhea/Dysmenorrhea _____			Ovarian cysts _____			Sexually Transmitted Infections _____			Other:		
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REQUIREMENT

Forms postmarked after January 9, 2012 will be assessed a \$75 late fee.

For the safety of our campus community, new students will not be allowed to move into student housing unless their immunizations are up-to-date and have been reviewed by the Hope Health Center staff.

Students are required to keep their immunization status up-to-date throughout their stay at Hope to avoid a hold on their class registration.

Students requesting an immunization waiver must complete the Hope College immunization waiver. Available at www.hope.edu/admin/healthcenter

STATEMENT OF AUTHORIZATION

- The information contained on this form is complete and I have not withheld any medical or mental health information. If any aspect of my health profile changes after submitting this form, I will notify the Hope Health Center of this/these changes in writing.
- I authorize the Student Health Center of Hope College to administer medical and surgical services, including immunizations and to perform routine and emergency diagnostic and therapeutic procedures as deemed necessary by duly licensed medical personnel. I understand that the Medical Director, or designee, serves as primary physician for medical care provided by the Hope Health Center.
- I understand that I will be required to undergo medical treatment for any current or future diagnosis of Latent Tuberculosis Infection (LTBI). *Failure to do so will result in withdrawal from current coursework and living arrangements at Hope College.*

Signature of Student

Date