McDANIEL COLLEGE

The Wellness Center
Winslow Center
2 College Hill
Westminster, MD 21157
Tel: 410-857-2243
Fax: 410-857-2703

OFFICE USE ONLY:

Date Received:_____

Method Received:_____

Student ID#:_____

Email:_____

PRE-ENTRANCE STUDENT HEALTH FORM

DUE DATES: July 15th (Fall admission) **January 15th** (Spring Admission)

Step 1: Student completes Part 1: Student Information, Part 2: Medical History, and Part 4A: Tuberculosis Screening Questions

Step 2: Health care provider reviews student portion and completes Part 3: Immunizations, Part 4B: Tuberculosis Testing and Clinical Assessment, and Part 5: Health Care Provider Signature

Step 3: Submit entire form with copy of official immunization record and copy of insurance card

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

Step 4: It is strongly recommended that students contact the Wellness Center to confirm receipt and completeness of submitted form.

Step 5: Keep a copy of all completed forms for your records

IMPORTANT INFORMATION ABOUT REQUIRED PRE-ENTRANCE STUDENT HEALTH FORM:

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. **Failure to submit this form or submission of a form with incomplete or illegible information will result in a non-refundable $500 fine and the student will not be eligible to utilize Student Health Services in the Wellness Center until the form is completed. Residential students will not be able to move into college housing until they have submitted documentation of receiving the meningococcal vaccine or signed the waiver.**

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.

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 athletics packet is available at www.mcdanielathletics.com/information/athletic-training/athlete-packet-index. For questions about the required athletic forms, contact Gregg Nibbelink, MS, LAT, ATC, head athletic trainer, gnibbeli@mcdaniel.edu or Stephanie Roby, MS, LAT, ATC, assistant athletic trainer, sroby@mcdaniel.edu

Disability Services and Special Housing Considerations: Students with documented disabilities are encouraged to register with Student Academic Support Services (SASS) at 410-857-2504 to ensure their specific academic needs will be addressed during their time at McDaniel. Requests for special housing considerations must be directed to the Office of Residence Life at 410-857-2240.

PART 1: 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 **September 15th** by completing the waiver found at https://secure.visit-aci.com/insurance/RCMDschool. 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 that they are enrolled in McDaniel College. Please review your current plan to be sure that 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 2: 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. 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 3: IMMUNIZATIONS

Please attach a copy of your official immunization record.

All required immunization information will need to be verified by health care provider's signature on this form OR an official immunization record must be attached. Official immunization documentation may include: copy of high school immunization record, immunization from health care provider with official stamp or signature, or International certificate of vaccination (in English).

REQUIRED IMMUNIZATIONS		
Immunization	**Dates Given**	**Requirements**
MMR (Measles, Mumps, Rubella)	Dose 1:____/____/____ (Mo Day Year) Dose 2:____/____/____ (Mo Day Year) OR Measles Dose 1:____/____/____ (Mo Day Year) Dose 2:____/____/____ (Mo Day Year) Mumps Dose 1:____/____/____ (Mo Day Year) Dose 2:____/____/____ (Mo Day Year) Rubella Dose 1:____/____/____ (Mo Day Year) Dose 2:____/____/____ (Mo Day Year)	2 doses of combined MMR OR 2 doses of each individual vaccine (measles, mumps, and rubella) • First dose given after 1st birthday • At least 4 weeks between doses OR Positive blood tests showing immunity to measles, mumps, and rubella • Lab report of titers must be attached
Tdap (Tetanus–Diptheria-Pertussis) OR **Td (Tetanus-Diptheria**	Tdap:____/____/____ (Mo Day Year) OR Td:____/____/____ (Mo Day Year)	One booster within the past 10 years Do not confuse the adult Tdap with the DTaP vaccine given before age 7 Tdap is strongly recommended over Td
Meningococcal (Meningitis)	____/____/____ (Mo Day Year) ☐ Menactra ☐ Menveo ☐ Other **If vaccine has not been received, a waiver must be signed.** Meningitis information can be found here: **https://phpa.health.maryland.gov/OIDEOR/IMMUN/Pages/meningococcal-disease.aspx** I have received and reviewed the information provided on the risk of meningococcal disease and the effectiveness and availability of the meningococcal vaccine. I understand that meningococcal disease is a rare but life-threatening illness. I understand that Maryland law requires an individual enrolled in an institution of higher education in Maryland who resides on campus in student housing to receive vaccination against meningococcal disease unless the individual signs a waiver. I choose to waive the meningococcal vaccine. _____ Student Signature _____ Parent/Legal Guardian (if student is under 18)	One dose of the 4-valent (ACYW) meningococcal conjugate after age 16 **All undergraduate students must either be vaccinated against meningococcal disease or complete a waiver before they can move into college housing.**

RECOMMENDED IMMUNIZATIONS	
Immunization	**Dates Given**
Varicella (chicken pox)	Dose 1:____/____/____ Dose 2:____/____/____ Mo Day Year Date of Varicella Disease ____/____/____ Mo Day Year OR ____/____/____ Mo Day Year
Hepatitis A	Dose 1:____/____/____ Mo Day Year Dose 2:____/____/____ Mo Day Year
Hepatitis B	Dose 1:____/____/____ Mo Day Year Dose 2:____/____/____ Mo Day Year Dose 3:____/____/____ Mo Day Year
Human Papillomavirus (HPV)	Dose 1:____/____/____ Mo Day Year Dose 2:____/____/____ Mo Day Year Dose 3:____/____/____ Mo Day Year
Serogroup B Meningococcal	Dose 1:____/____/____ Mo Day Year Dose 2:____/____/____ Mo Day Year Dose 3:____/____/____ Mo Day Year ☐ Bexsero ☐ Trumenba
Polio (IPV or OPV)	Completed primary series ☐ Yes ☐ No Date of last dose: ____/____/____ Mo Day Year

PART 4: TUBERCULOSIS RISK ASSESSMENT (Required for ALL Students)

A. 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

If you answered YES to any of the above questions, McDaniel requires that you receive TB testing. ⟹ Proceed to Section B on the next page.

If you answered **NO** to all of the above questions, no further action is required.

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

B. Tuberculosis Testing and Clinical Assessment (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: _____

PART 5: HEALTH CARE PROVIDER SIGNATURE

Health Care Provider Information: *I have reviewed all of the information on this form including immunization record and TB Risk Assessment and certify that it is complete and accurate.*

_____

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

_____

Address | Phone Number | Fax Number