



2010 – 2011

# HEALTH INFORMATION FORMS



Be The Difference.

**Marquette University Student Health Service**  
a division of Student Affairs

Schroeder Complex, lower level  
545 N. 15<sup>th</sup> St.  
Milwaukee, WI 53233  
PHONE: 414-288-7184 FAX: 414-288-5681  
E-mail: [immunizations@marquette.edu](mailto:immunizations@marquette.edu)

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**MARQUETTE UNIVERSITY REQUIRED IMMUNIZATION RECORD,  
TUBERCULOSIS SCREENING AND MEDICAL HISTORY FORM**

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Welcome to Marquette University. The Student Health Service provides students with a broad range of primary care, health promotion and disease prevention services. The SHS Web site provides helpful details: [www.marquette.edu/shs](http://www.marquette.edu/shs).

Enclosed you will find a prematriculation immunization record, tuberculosis screening and medical history forms. Marquette University **requires** all newly admitted or readmitted undergraduate, graduate, professional and transfer students to submit proof of the following:

- **1 Tetanus-Diphtheria (Td or Tdap) booster within the past 10 years**
- **2 MMR (measles, mumps, rubella) vaccines OR 2 Measles, 1 Mumps, 1 Rubella vaccine;**  
Dose 1 on or after the first birthday; dose 2 must be at least one month after the first dose.  
If immunization date is not available, a laboratory report of a blood test (titer) showing immunity will be accepted.  
Vaccine/titer not required for those born prior to 1957.
- **History of chickenpox disease OR varicella vaccine OR positive blood titer**  
Two doses of vaccine required
- **Tuberculosis screening questionnaire and results of tuberculosis testing/PPD if indicated**

In order to avoid delays, complete these forms or see your health care provider as soon as possible, especially if your immunizations are incomplete, and to get any required immunizations. Required immunizations are available from your health care provider, local health departments or the Marquette Student Health Service. You may contact SHS to arrange an appointment for any necessary immunizations and tests.

The information you submit will be maintained by the Student Health Service and will not be released to anyone without your knowledge and consent.

**HEALTH SCIENCE, DENTAL AND NURSING STUDENTS** may be required by their department to receive additional immunizations. **Contact your department for specifications.**

Please return your completed forms to the address noted above 30 days prior to the start of your first session/term or immediately upon your arrival at Marquette University. **Failure to return your completed forms within 30 days after the start of your first session/term at Marquette will result in a medical hold preventing future registrations.**

Questions may be directed to [immunizations@marquette.edu](mailto:immunizations@marquette.edu) or (414) 288-7184.

PLEASE COMPLETE ALL PARTS OF THIS FORM, AND MAKE A COPY OF THESE FORMS BEFORE SUBMITTING.

Marquette University Student Health Service

Schroeder Complex, lower level  
 545 N. 15<sup>th</sup> St.  
 Milwaukee, WI 53233  
 Phone: (414) 288-7184 Fax: (414) 288-5681

Self-reported immunization record

SHS use only	Date received ___/___/___
MMR #1 ___ #2 ___ Td ___ Varicella ___ TB ___	
Complete Y N	Entered Y N
Reviewed by: ___	Date hold removed: ___

All newly admitted or readmitted students are required to return this completed form to Student Health Services at the address above within 30 days of the start of the session/term of enrollment. **Failure to show proof of immunizations will result in a block in your registration for subsequent sessions/terms.**

_____			GENDER: M F
LAST NAME (print)	FIRST NAME	MIDDLE	
_____	_____	_____	
DATE OF BIRTH	COUNTRY OF BIRTH	MARQUETTE ID # (MUID #)	MU E-MAIL
_____	_____	_____	_____
PERMANENT ADDRESS	CITY	STATE	ZIP CODE AREA CODE/PHONE NUMBER
_____	_____	_____	_____

CLASS YOU ARE ENTERING (circle): UNDERGRAD GRAD PROF NON-DEGREE	SEMESTER/TERM ENTERING (circle): FALL SPRING SUMMER OTHER	ENTRANCE YEAR _____
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**REQUIRED IMMUNIZATIONS**

Please complete this form as soon as possible. You may obtain dates/documentation from your health care provider or previous school records. If documentation/data is unavailable, a laboratory report of a blood test (titer) to determine level of immunity or re-immunization is required. Immunizations are available at the Marquette University Student Health Service for a fee. Call (414) 288-7184 for an appointment.

**1. TETANUS/DIPHtherIA (Td or Tdap)**

Booster dose within 10 years Booster: \_\_\_/\_\_\_/\_\_\_  
 (mos) (day) (year)

**2. MMR (measles, mumps, rubella)**

Immunization with two doses of MMR, given on or after first birthday and separated by at least one month

MMR #1 \_\_\_/\_\_\_/\_\_\_ MMR #2 \_\_\_/\_\_\_/\_\_\_  
 (mos) (day) (year) (mos) (day) (year)

**OR**

Measles #1 \_\_\_/\_\_\_/\_\_\_ Measles #2 \_\_\_/\_\_\_/\_\_\_ or attached lab report showing positive immunity \_\_\_  
 (mos) (day) (year) (mos) (day) (year)  
 Mumps \_\_\_/\_\_\_/\_\_\_ (Date of last dose) or attached lab report showing positive immunity \_\_\_  
 (mos) (day) (year)  
 Rubella \_\_\_/\_\_\_/\_\_\_ (Date of last dose) or attached lab report showing positive immunity \_\_\_  
 (mos) (day) (year)

**3. VARICELLA**

History of chickenpox disease, immunization (two doses) or positive titer  
 Date of chickenpox disease \_\_\_/\_\_\_/\_\_\_ or attached lab report showing positive immunity \_\_\_  
 (mos) (year)

**OR**

Varicella #1 \_\_\_/\_\_\_/\_\_\_ Varicella #2 \_\_\_/\_\_\_/\_\_\_  
 (mos) (day) (year) (mos) (day) (year)

**RECOMMENDED IMMUNIZATIONS**

**Meningitis vaccine**  
 Dose: \_\_\_/\_\_\_/\_\_\_

**Hepatitis B**  
 Series of 3 doses; 0, 1, 6 months  
 Date #1: \_\_\_/\_\_\_/\_\_\_  
 Date #2: \_\_\_/\_\_\_/\_\_\_  
 Date #3: \_\_\_/\_\_\_/\_\_\_

**Polio**  
 Three doses  
 Date #1: \_\_\_/\_\_\_/\_\_\_  
 Date #2: \_\_\_/\_\_\_/\_\_\_  
 Date #3: \_\_\_/\_\_\_/\_\_\_

**I HAVE READ AND UNDERSTAND THE IMMUNIZATION REQUIREMENTS OF THIS FORM AND THE ENCLOSED INFORMATION.** This form has been truthfully completed to the best of my knowledge, and I freely consent to this form being used for my treatment at Marquette University.

Student signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent signature (if under 18 years of age): \_\_\_\_\_ Date: \_\_\_\_\_

## TUBERCULOSIS QUESTIONNAIRE

**All newly admitted students are required to submit this completed form to the Student Health Service within 30 days of the start of the session/term of enrollment**

**NAME:** \_\_\_\_\_ **MU ID#:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**To answer the following questions, please refer to the list below which details the list of countries with high rates of TB.\***

Afghanistan	Chad	Guinea	Macao SAR	Nigeria	Sri Lanka
Angola	China	Guinea-Biss	Macedonia	Niue	Sudan
Armenia	Columbia	Guyana	Madagascar	N. Mariana Is.	Suriname
Azerbaijan	Comoros	Haiti	Malawi	Pakistan	Swaziland
Bahamas	Congo	Herzegovina	Malaysia	Palau	Syrian A.R.
Bahrain	Congo, DR	Honduras	Maldives	Panama	Tajikistan
Bangladesh	Cote D'Ivoire	Hong Kong SAR	Mali	Papua N.G.	Tanzania UR
Belarus	Croatia	India	Marshall Is.	Paraguay	Thailand
Benin	Djibouti	Indonesia	Mauritania	Peru	Togo
Bhutan	Dominican Republic	Iran	Mauritius	Philippines	Tokelau
Bolivia	Ecuador	Kazakhstan	Micronesia	Portugal	Turkmenistan
Bosnia	El Salvador	Kenya	Moldova Rep.	Principe	Uganda
Botswana	Equ. Guinea	Kiribati	Mongolia	Romania	Ukraine
Brazil	Eritrea	Korea, DPR	Morocco	Russian Fed.	Uzbekistan
Brunei Dar.	Estonia	Korea Rep.	Mozambique	Rwanda	Vanuata
Burkina Faso	Ethiopia	Kyrgyzstan	Myanmar	Sao Tome	Vietnam
Burundi	Gabon	Lao PDR	Namibia	Senegal	Yemen
Cambodia	Georgia	Latvia	Nepal	Sierra Leone	Zambia
Cameroon	Ghana	Lesotho	N. Caledonia	Soloman Is.	Zimbabwe
Cape Verde	Guam	Liberia	Nicaragua	Somalia	
Cen. Afr. Rep.	Guatemala	Lithuania	Niger	So. Africa	

\*World Health Organization. Global Tuberculosis Control. WHO Report 2002.

1. To the best of your knowledge, have you had close contact with anyone who was sick with tuberculosis (TB)?  YES  NO
2. Were you born in one of the countries on the above list?  YES  NO
3. Have you lived or traveled for more than one month in any of the countries on the above list?  YES  NO

**If you have answered YES to any of the above questions, a PPD (Mantoux) skin test is required, even if you have had BCG vaccination in the past. Test must have been performed within one year before enrollment and must be completed in the United States.**

This test will be available, if necessary, at the Marquette Student Health Service after you arrive on campus. Please contact SHS by telephone (414-288-7184) for an appointment.

Health Care Provider must complete and sign below as proof of test:

TB (PPD) Skin Test	Skin Test Result (size of induration)	Chest X-Ray Required if TB skin test is positive	Health Care Provider	Treatment (if any)
Date Administered:  _____	_____ mm	_____ Date of X-ray	Signature _____	
Date Test Read:  _____	Signature of Health Care Provider	Result: NEG POS  (attach copy of written report)	Address: _____  _____	

### Medical History

Please answer all questions. Consult your health care provider and parents for accurate, complete answers. The information is treated confidentially and will not affect your admission status.

Name: \_\_\_\_\_ MU ID#: \_\_\_\_\_ Date: \_\_\_\_\_  
LAST FIRST MIDDLE

List any chronic or recurrent medical conditions or any condition that you regularly take medication for:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  None

List any medical problems in any of your immediate family members (parents, siblings, grandparents) for example, high blood pressure, diabetes, cancer, etc.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  None

List any past surgeries, serious illness, injuries or hospitalizations:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  None

List current medications (including oral contraceptives):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  None

Are you currently under a physician's care?  Yes  No If yes, explain:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List medication allergies or adverse drug reactions (include type of reaction):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  None

Name and address of current physician(s):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Insurance Data

Are you in an HMO or PPO?  Yes  No

Name of insurance company: \_\_\_\_\_ Group No.: \_\_\_\_\_

Cert. No.: \_\_\_\_\_ Insurance phone number to call in emergency: \_\_\_\_\_

Please obtain a copy of your medical insurance card to keep it with you.

### Emergency Contact

Name: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Home telephone: ( ) \_\_\_\_\_ Work telephone: ( ) \_\_\_\_\_

### Parental consent for care of students under age 18

The law requires that a parent/guardian grant permission for medical evaluation and/or treatment of minors (anyone under 18 years of age). The following consent must be signed by a parent/guardian of a minor so that he/she may receive medical evaluation/treatment. No major medical or surgical procedure will be performed, except in an emergency, without the parent/guardian first being contacted.

Authorization: I concur with the above and authorize, at the discretion of Student Health Service personnel, medical and surgical care including examinations, treatments, immunizations and the like for my son or daughter. In the event of serious disease or injury or the need for major surgery, I understand that all reasonable efforts will be made to contact me, but that failure to make contact will not prevent emergency treatment necessary to help preserve life or health.

Name of parent/guardian: \_\_\_\_\_ Work telephone: ( ) \_\_\_\_\_

Signature of parent/guardian: \_\_\_\_\_ Date: \_\_\_\_\_



## Meningitis and Hepatitis B Legislation

Effective January 1, 2004 all public and private universities in the state of Wisconsin are required by law to provide students with information on the risks associated with Meningococcal Disease and Hepatitis B and the availability and effectiveness of vaccines against these diseases. All students living in residence halls must affirm that they have received this information and whether or not they have been vaccinated against Meningitis and/or Hepatitis B. Neither the law nor the University requires you to have the vaccines.

You can find information on these diseases on our Health Topics portion of our Clinical Services page. Once reviewed, please download and complete the Affirmation Statement. If you are under the age of 18, the signature of your parent is required.

Please return the completed form to:

Student Health Services  
545 N. 15th St.  
Milwaukee, WI 53233

**This form must be completed and returned prior to the receipt of your residence hall room key.**

## Meningitis and Hepatitis B Affirmation Form

Do you know about meningococcal disease?

I have reviewed this information and:

I intend to or have received meningococcal vaccine

\_\_\_\_\_  
DATE OF VACCINATION

I do not intend to receive meningococcal vaccine

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
DATE OF BIRTH

\_\_\_\_\_  
SIGNATURE DATE

Do you know about Hepatitis B?

I have reviewed this information and:

I intend to or have received Hepatitis B vaccine

\_\_\_\_\_  
DATE OF VACCINATIONS

I do not intend to receive Hepatitis vaccine

## Health Information Forms

Meningococcal disease is a rare but serious illness caused by bacteria that infect the blood or membranes surrounding the brain and spinal cord. It can lead to brain damage, disability and death.

It is most common in infants and in people with certain medical conditions. College **freshmen** living in residence halls have a modestly increased risk of getting the disease. About 100 cases occur on college campuses in the U.S. each year, resulting in 5-15 deaths. Common **symptoms** of meningitis include stiff neck, headache, fever, sensitivity to light, sleepiness, vomiting, confusion and seizures.

Meningitis can be treated with antibiotics. However, because the disease progresses rapidly, **treatment must be started early**. Despite treatment, 10-20% of people suffer long-term consequences.

A **meningococcal vaccine** is available from your doctor or the student health service. It protects against four of the five most common types of bacteria and can prevent 50-70% of cases on college campuses.

Hepatitis B is a **serious** viral disease that attacks the liver. It can lead to lifelong infection, cirrhosis (scarring of the liver), liver cancer and death.

Hepatitis B is easier to catch than you may realize. The highest rate of disease occurs in 20-49 year olds. The virus is found mainly in blood, semen and vaginal fluid. If you come into **frequent contact** with blood or other body fluids, have unprotected sex, share needles when injecting illegal drugs or get stuck with a needle on the job, you can get infected. About one-third of people infected with Hepatitis B don't know how they got it.

**Common symptoms** include yellowing of the skin and eyes, abdominal pain, fatigue, diarrhea and loss of appetite. Chronic liver disease can develop.

There is no treatment for Hepatitis B infection when you first get it. **Preventing infection** is the most important.

**Hepatitis B vaccine** is available from your doctor or the student health service. It effectively prevents Hepatitis B disease and its serious consequences. Three doses over six months are commonly needed for complete protection,. Everyone 18 years of age and younger and adults whose behavior or occupation puts them at risk for Hepatitis B infection should be vaccinated.