STUDENT HEALTH SERVICES
THE UNIVERSITY OF NORTH DAKOTA

John A. Swenson Student Health Services
McCannel Hall, Room 100
2891 2nd Avenue N., Stop 9038
Grand Forks, ND 58202-9038
Phone: 701.777.4500 Fax: 701.777.4835

Instruction Sheet for Health History and Immunization Form

Accurate and complete immunization information is required for registration at UND.
Do Not Delay! Obtaining proof of immunization may be a time-consuming process, so start now.
Incomplete information may result in your form being returned to you and your registration being delayed or blocked.
Return completed forms as soon as reasonably possible.

✓ **Part I. Name/address etc:** Print all information legibly. All information fields in this section are required.

✓ **Part II. Verification of Immunizations:**

Required Immunizations
MMR: All students born after 1956 are required to provide documentation of two (2) administered doses of Measles, Mumps, and Rubella or provide documentation of titers proving immunity to each disease. UND will accept official copies of immunization records issued by local health departments, physician offices or school records. The first dose must have been given after your first birthday and the second dose must be at least a month apart from the first dose.
Meningococcal: Effective Fall 2012, all newly admitted students, ages 21 and younger residing in campus housing, must provide documentation of immunity against meningococcal disease. One dose must have been given after the 16th birthday.

Recommended Immunizations
Tetanus/Diphtheria: 1 booster shot within the past 10 years.
Gardasil: For females and males between the ages of 9-26.
Hepatitis A: Two doses administered 6 months apart.
Hepatitis B: Students in many Academic Health Programs are required to have this series.
Varicella: History of disease or vaccination (2 doses) is acceptable.
Polio: Childhood series of 4 shots. One adult dose may be needed if traveling to foreign countries.
Pneumococcal: Per physician recommendation.
Influenza: One dose yearly given in the fall.

If you have medical or religious reasons for not receiving the required vaccinations, please complete the Medical/Conscientious Exemption section of this form. A physician signature is required for the Medical Exemption and a Notary signature and seal must accompany a Conscientious Exemption.

✓ **Part III: Health History**
Please answer all questions that pertain to your health status.

✓ **Part IV: Health Insurance Information**
Please print all information legibly and attach a copy of your insurance card (front and back).

✓ **Signatures:**
Signature of the student accompanied by a signature of a parent or guardian is required.

✓ **Part V: TB (Tuberculosis) Screening Questionnaire: All students are required to fill out the questionnaire and return it to Student Health Services**.
Please locate the attached TB Screening Questionnaire and answer questions. If you answer yes to any of the questions in Part B., Mantoux skin testing or a Quantiferon Gold blood test will need to be done and documentation of results from a physician within the United States obtained prior to starting classes. If you have tested positive in the past, documentation of a negative chest x-ray done in the United States will be needed. TB (Mantoux) testing can be done at UND Student Health Services for $10.00. Please call for an appointment at 777-2605.
If you answered "None of the following apply" then you do not need to do TB testing.

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MANDATORY HEALTH HISTORY AND IMMUNIZATION FORM

Part I - To be completed by the Student (Please Print)

Last	*First*	*Preferred/Nickname*	*M.I.*
Address:	*City*	*State*	*Country*	*Zip*
Date of Birth: / /	*Sex :* M ☐ F ☐ *Other:* ☐	*UND ID#*	
Local Telephone Number: ( )	*Cellular Telephone Number:* ( )		
Next of Kin (Name):	*Relationship to Student*	*Telephone Number* ( )	
Address:	*City*	*State*	*Country*	*Zip*

Part II VERIFICATION OF IMMUNIZATIONS – To be completed by Health Care Provider or Public Health Official

The North Dakota State Board of Higher Education Policy #506.1 ***requires*** all students enrolled in a course offered for credit at any institution must provide documentation of immunity against measles, mumps and rubella and documentation of vaccination against meningitis with one meningitis dose being given after the 16th birthday. All students must be screened for tuberculosis (TB); please complete Part V of this form. **Failure to comply with the above stated requirements will result in a hold on the student's ability to register for the upcoming semester at UND.**

☐ Online Student Only: Students enrolled only in distance learning courses, courses taught off campus, continuing education or non-credit courses are exempt from this policy.

	VACCINE	M/D/Y GIVEN	VACCINE	M/D/Y GIVEN	VACCINE	M/D/Y GIVEN
REQUIRED	**MMR 1**		**MMR 2**			
	Meningococcal					
	TB Skin Test (If indicated on Screening Form)	Two-Step Indicated? Y or N	Date/Time Placed #1	Date/Time Read/mm	Date/Time Placed #2	Date/Time Read/mm
RECOMMENDED	**Tetanus/Diphtheria**					
	Gardasil 1		**Gardasil 2**		**Gardasil 3**	
	Hepatitis A 1		**Hepatitis A 2**			
	Hepatitis B 1		**Hepatitis B 2**		**Hepatitis B 3**	
	Varicella					
	Polio IPV/OPV					
	Pneumococcal					

Signature of Healthcare Provider:_____ **Date:** _____

An Official/Signed Immunization Record may be substituted for this section.

If you have medical, conscientious, or religious reasons for not receiving the required vaccinations, please complete appropriate exemption below.

Medical Exemption: The student named above does not have one or more of the required immunizations because he/she has (check all that apply and fill in the appropriate blanks):

- ☐ A medical problem that precludes the _____ vaccine(s).
- ☐ Not been immunized because of a history of _____ disease(s).
- ☐ Shown laboratory evidence of immunity against _____

Healthcare Provider signature _____ **Date** _____
(Required for medical exemption)

Or

Conscientious Exemption: I hereby certify that immunization against _____ is contrary to my conscientiously-held and/or religious beliefs.

Student's signature _____ **Date** _____

In the event of an outbreak of a communicable disease in which immunization is required, it may be determined that exclusion from campus and campus activities may be recommended/required by the Student Health Services Medical Director/Local Public Health Officer until the danger of the epidemic is over.

Name: _____ **UND ID#** _____

Part III HEALTH HISTORY - To be completed by the Student

LIST ANY MEDICATIONS YOU ARE ALLERGIC TO	
Medication	**Allergic Reaction Experienced**

☐ **Allergies/Environmental Sensitivities:**_____
Please list

☐ **Latex Allergy**

If you have had any of the following, please check 'yes'. Explain YES answers in the space provided.

	YES		YES		YES		YES		YES
SKIN		**RESPIRATORY**		**GENITOURINARY**		**MUSCULOSKELETAL**		**ENDOCRINE**	
Acne		Asthma		Urinary Tract Infection		Arthritis		Diabetes	
Other Skin Problems		Chronic Cough		Kidney Stones or Disease		Fracture or Dislocations		Sudden Weight Change	
EYES		Bronchitis or Pneumonia		Sexually Transmitted Infection		Back/Disc Problems		Thyroid Problem/Disease	
Eye Injury/Disease		**CARDIAC**		**WOMEN:**		Scoliosis		**HEMATOLOGIC**	
EAR/NOSE/THROAT		High Blood Pressure		Menstrual Irregularity		**NEUROLOGICAL**		Anemia/Low Iron	
Hearing Loss/Deafness		High Cholesterol		Severe Cramps		Migraines		Sickle Cell Trait/Disease	
Frequent Ear Infections		Irregular Heart Rate		Abnormal Pap Smear		Frequent Headaches		Blood Clotting Disorder	
Perforated Eardrum		Heart Murmur		Breast Problems		Concussion/Head Injury		**INFECTIOUS DISEASE**	
Repeated Nosebleeds		History of Palpitations		Pelvic Inflammatory Disease		Dizziness/Fainting		Mononucleosis	
Sinus Infections		Chest Pain		**MEN:**		Insomnia		Whooping Cough	
Frequent Sore Throats		**GASTROINTESTINAL**		Epididymitis		Neuromuscular Disorder		Meningitis	
Tonsils/Adenoids Surgery		Stomach Problems/Ulcer		Testicular Torsion		Weakness/Paralysis		**OTHER PROBLEMS**	
DENTAL		Requires Special Diet		Loss/Damaged Testicle		Seizures/Epilepsy			
Bleeding Gums		Hepatitis		Undescended Testicle		**MENTAL HEALTH**			
Poor Teeth		Gallbladder Problems		Testicular Cancer		Anxiety Disorder			
		Irritable Bowel Problems				Depression			
		Hemorrhoid Problems				Anorexia and/or Bulimia			
		Hernia				Suicide Attempt			
						ADD/ADHD			

DESCRIBE details for each 'yes' with dates. Please use an extra page if space is not adequate.

_____

_____

_____

Do you have any other health related conditions not listed above? _____

_____

☐ Hospitalization/Surgeries (list date/purpose or type) _____

_____

FAMILY HISTORY

	Age	Health Problems	Age at Death	Cause of Death
Mother				
Father				
Siblings				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				

Name: _____ **UND ID#** _____

LIST ALL CURRENT MEDICATIONS *Please include all over-the-counter medications, supplements and alternative therapies (herbs, aroma, etc)*					
Medication	**Dose/Route**	**Purpose**	**Medication**	**Dose/Route**	**Purpose**

Part IV HEALTH INSURANCE INFORMATION – To be completed by the Student ****Please attach a copy of your health insurance card (*front & back*)****			
Name of Insurance Co./address *Policy #*	*Policy #*		
Policy Holder	*Last Name:*	*First Name:*	*MI:*
Policy Holder DOB	*Relationship to Student:*		

SIGNATURES REQUIRED:

- **I certify to the best of my knowledge that the information on this form is complete and correct**.

  STUDENT NAME (PLEASE PRINT) _____

  STUDENT SIGNATURE: _____ DATE _____

- **CONSENT FOR MINOR (UNDER 18 YEARS OF AGE):** I give my permission for medical treatment/testing for my daughter/son while she/he is a student at the University of North Dakota. This would include referral to an area medical provider, clinic, or hospital which may result in her/his hospitalization, anesthesia, and surgery should it be necessary and I am unable to be reached.

  PARENT/GUARDIAN'S NAME (PLEASE PRINT) _____ RELATIONSHIP _____

  SIGNATURE OF PARENT/GUARDIAN _____ DATE _____

  STUDENT NAME _____ (PRINT)

Please return completed form to:
Student Health, McCannel Hall, Room 100
2891 2nd Avenue North, Stop 9038
Grand Forks, ND 58202-9038
or
Fax: (701) 777-4835

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Part V Tuberculosis (TB) Screening Documentation
ALL STUDENTS ARE REQUIRED TO FILL OUT & RETURN THIS FORM

Name: _____ Date of Birth: _____

The University of North Dakota requires documentation of Tuberculosis (TB) screening within 6 months prior to or 1 semester after college entrance with a Mantoux skin test for those students meeting the following criteria noted in Section B.

A. ☐ **If none of the following apply, please check this box - <u>You do not need TB skin testing</u>.**

B. Check all that apply:

- ☐ Contact with a person known to have active tuberculosis
- ☐ Signs or symptoms of active TB such as chronic cough, bloody sputum, fever, night sweats or weight loss
- ☐ Healthcare worker
- ☐ Volunteer or employee of a nursing home, prison or other residential institutions
- ☐ History of illicit drug use
- ☐ Have been diagnosed with a chronic medical condition that may impair your immune system:
  - ☐ Cancer of the head and neck or lung
  - ☐ Chronic malabsorption
  - ☐ Chronic renal failure
  - ☐ Diabetes mellitus
  - ☐ Intestinal bypass or gastrectomy (stomach removal)
  - ☐ Leukemias, lymphoma or Hodgkin's Disease
  - ☐ Low body weight (10% or more below ideal or BMI of 18 or less)
  - ☐ Organ transplantation
  - ☐ Silicosis
  - ☐ Immunosuppressed from steroid use receiving equivalent of Prednisone 15 mg/day or more for 1 month or more.
- ☐ From or have lived for 1 month in Asia, Africa, Central America, South America or Eastern Europe. This includes all countries **<u>EXCEPT</u>** for the following countries noted, which have a low prevalence of TB:

American Region:

Canada	Jamaica	Saint Kitts & Nevis
St. Lucia	Virgin Islands	USA

European Region:

Belgium	Denmark	Finland
France	Germany	Greece
Iceland	Ireland	Italy
Liechtenstein	Luxembourg	Malta
Monaco	Netherlands	Norway
San Marino	Sweden	Switzerland
United Kingdom		

Western Pacific Region:

American Samoa	Australia	New Zealand

<u>If any of the above do apply, TB testing is required</u>:

☐ **TB skin testing** – Call UND Student Health at 777-2605 to schedule an appointment for testing.

Or

☐ **Provide documentation of TB testing <u>done in the United States</u>** within the past 6 months by a healthcare provider. PPD Mantoux skin test read and documentation in millimeters of induration. A chest x-ray performed in the US will be required for anyone with a positive skin test. A negative chest x-ray is not a substitute for a skin test.

Or

☐ **Provide documentation of prior treatment of active TB disease.**