Northwestern University Health Service
Health Information Management Services Department

Northwestern HEALTH SERVICE

ADMISSION HEALTH RECORD

for students in **NON-HEALTHCARE ACADEMIC PROGRAMS**

Deadline for Mailing the Admission Health Record Form
Students accepted after the term deadline listed below have 30 days from date of acceptance to complete this form.

Fall Entrants	Winter Entrants	Spring Entrants	Summer Entrants
July 1	December 1	March 15	May 1

Instructions – Read prior to completing this form

1. **Students in non-healthcare programs (use this form)** – All full-time or half-time students (registered for 2 or more classes) are required to complete Parts I, III, IV and V. If under 18, also complete Part VI with your parent/guardian.
2. **Students in a graduate healthcare program (do not use this form)** – Example: Medical, PT, PA, Genetic Counseling, Communication Science and Disorders (excluding MSC) or Prosthetic-Orthotic. Complete the appropriate form on the Health Services forms website: http://www.northwestern.edu/healthservice-evanston/
3. **Proof of Immunization** – Provide proof of immunization by submitting one of the following:
   - Part II Required Immunizations (page 2) must be completed, signed, and dated by a healthcare professional.

   OR
   - Submit a copy of your immunization record from your physician, former high school or university, immigration paperwork, or other official immunization record. Any paperwork must list all required immunizations.
4. **No Immunization Record** – If you have no immunization records, you have the option to complete blood tests to prove immunity or to be re-vaccinated.
5. **Entrance Health Requirements** – For detailed information, visit the Evanston campus Health Service website: http://www.northwestern.edu/healthservice-evanston/new-incoming-students/entrance-health-requirements/index.html
6. **Health Requirements FAQs** – Visit the Evanston campus Health Services website: http://www.northwestern.edu/healthservice-evanston/new-incoming-students/health-requirements-faqs/index.html
7. **Penalties** – Students who fail to submit the completed *Admission Health Record*, including proof of immunizations and fail to rectify deficiencies within 30 days after the start of classes will be:
   - Assessed a non-refundable $100 late fee
   - Barred from class registration for subsequent terms until compliant in accordance with Illinois law
8. **Completed Forms** – Mail to Northwestern University Health Service, Health Information Management Service, 633 Emerson Street, Evanston, IL 60208
9. **Confirmation –** Your Northwestern email address will be used to communicate completion of admission health requirements or any immunization deficiencies.

PART I: STUDENT AND ACADEMIC INFORMATION

_____ _____
Last name First name Middle Preferred name

_____
Permanent Address

_____ _____
Date of Birth (mm/dd/yyyy) Student ID (7 digit number)

Sex at birth ___ Female ___Male

Gender Identity ___Female ___Male ___Transfemale/MTF ___Transmale/FTM ___Transgender ___Gender-nonconforming
___ Different Identity: _____

Have you ever or are you currently serving in the US armed forces? ____ Yes ____ No

First Term attending and year of enrollment: Fall 20____ Winter 20____ Spring 20____ Summer 20____

I will be enrolled: ____ Half-Time (2 credits) ____ Full-Time (3 credits)

Indicate your academic program: ____ **Undergraduate** (all programs)

____ **Graduate** (check program below)
___ Law
___ Kellogg School of Management
___ Kellogg Executive Management/EMP
___ MS in Communication (MSC)
___ Other graduate (list program): _____

Northwestern University

PART II: REQUIRED IMMUNIZATIONS

FULL-TIME/HALF-TIME STUDENTS IN NON-HEALTHCARE PROGRAM

All full-time and half-time students are required by Northwestern and Illinois law to submit proof of immunization. **THIS PAGE MUST BE COMPLETED BY A HEALTHCARE PROVIDER (e.g. M.D., D.O., or Licensed Nurse),** and include their name (printed), signature and date at the bottom, 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. Vaccination dates should be listed in month/day/year format.

Student Name: _____ **Student ID:** _____ **Date of Birth:** _____

Students born prior to 1/1/1957 are NOT required to submit immunization records - enclose a copy of your driver's license instead of this page.

M-M-R (COMBINED Measles, Mumps, Rubella) vaccination (**2** doses required).

- **If given individually, complete section below instead.**

Dose #1 (on or after 1st birthday **AND** after 1/1/68): ____/____/_____ (mm/dd/yyyy)

Dose #2 (at least 28 days after dose #1): ____/____/_____ (mm/dd/yyyy)

MEASLES (Rubeola)

2 doses required. Both must be done on or after 1st birthday, after 1/1/68, and at least 28 days apart.

Dose #1: ____/____/_____

Dose #2: ____/____/_____

OR - **Attach copy of lab report** (titer) confirming immunity (antibodies).

MUMPS

2 doses required. Both must be done on or after 1st birthday, and at least 28 days apart.

Dose #1: ____/____/_____

Dose #2: ____/____/_____

OR - **Attach copy of lab report** (titer) confirming immunity (antibodies).

RUBELLA (German Measles)

2 doses required. Both must be done on or after 1st birthday, and at least 28 days apart.

Dose #1: ____/____/_____

Dose #2: ____/____/_____

OR - **Attach copy of lab report** (titer) confirming immunity (antibodies).

TETANUS/DIPHTHERIA/PERTUSSIS - 3 doses of DTP, DTaP, Td, DT or Tdap are required**.**

- The first 2 doses **MUST** be at least 28 days apart.
- The 3rd dose **MUST** be completed within **10 years** prior to entrance into University and at least 6 months after last primary series vaccination.
- One dose **MUST** be a Tdap, which is a vaccination only given to adolescents and adults; it is not given to infants or children.

☐**DTP/DTaP** ☐**Td** ☐**Tdap**	☐**DTP/DTaP** ☐**Td** ☐**Tdap**	☐**DTP/DTaP** ☐**Td** ☐**Tdap**
Dose #1: ____/____/_____	**Dose #2:** ____/____/_____	**Dose #3:** ____/____/_____

MENINGOCOCCAL CONJUGATE

- Required **ONLY** for students age 21 years or younger at the start of classes.
- MUST have been completed at 16 years of age or older.

Date: ____/____/_____

TUBERCULOSIS – Complete Part III: Tuberculosis Self-Screening on page 3 to determine if tests are needed. If your answers to the Tuberculosis Self-Screening instruct you to complete a TB test and you complete a PPD skin test, record the result here.

Date Placed: ___/____/_____ **Date Read:** ____/____/_____ **Result:** _____(millimeters)*

* If result is >= 10mm, refer to Instruction Set B of the Tuberculosis Self-Screening for additional requirements.

RECOMMENDED (NOT REQUIRED):

VARICELLA (Chicken pox) - Dose #1: ___/____/_____ **Dose #2:** ___/____/_____ **Date of Illness:** ___/____/_____

HEPATITIS B - Dose #1: ___/____/_____ **Dose #2:** ___/____/_____ **Dose #3:** ___/____/_____

HPV (Human Papillomavirus) - Dose #1: ___/____/_____ **Dose #2:** ___/____/_____ **Dose #3:** ___/____/_____

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)

NOTE: THIS SELF-SCREENING IS REQUIRED FOR FULL-TIME STUDENTS.
IT IS NOT REQUIRED FOR HALF-TIME OR KELLOGG EXECUTIVE MANAGEMENT STUDENTS.

Student Name: _____ **Student ID:** _____**Date of Birth:** _____

Begin with the 1st question and circle the appropriate response. If you answer "NO", proceed to the next question until all questions are answered. If you answer "YES" to any question, proceed to Instruction Set A or B as directed. Once you answer "YES" to a question, do not answer the remaining questions.

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 "A" below.**	**YES**	**NO**
2. Have you ever been diagnosed with tuberculosis? **IF "YES", follow Instruction Set "B" below.**	**YES**	**NO**
3. Have you ever had a positive skin test (PPD) or positive TB blood test? **IF "YES", follow Instruction Set "B" below.**	**YES**	**NO**
4. **In the last 5 years,** have you lived or traveled anywhere **other than** the countries listed below for a period **longer than 1 month**? **IF "YES", follow Instruction Set "A" below.**	**YES**	**NO**

Albania, American Samoa, Andorra, Antigua & Barbuda, Aruba, Australia, Austria, Bahamas, Barbados, Belgium, Bermuda, British Virgin Islands, Canada, Cayman Islands, Chile, Cook Islands, Costa Rica, Croatia, Cuba, Cyprus, Czech Republic, Denmark, Dominica, Egypt, Finland, France, Germany, Greece, Grenada, Hungary, Iceland, Ireland, Israel, Italy, Jamaica, Japan, Jordan, Lebanon, Luxembourg, Macedonia, Malta, Monaco, Montserrat, Montenegro, Netherlands, New Caledonia, New Zealand, Norway, Oman, Puerto Rico, St. Kitts & Nevis, St. Lucia, Slovakia, Slovenia, Samoa, San Marino, Saudi Arabia, Spain, Sweden, Switzerland, Syrian Arab Republic, Tokelau, Tonga, United Arab Emirates, United Kingdom, United States, US Virgin Islands, West Bank & Gaza.

5. Do you currently have one or more of the following medical conditions listed below? **IF "YES", follow Instruction Set "A" below.**			**YES** / **NO**
Diabetes Silicosis Chronic kidney failure Leukemia or lymphoma IV Drug Use Organ transplant	Low body weight (10% or more below ideal) Gastrectomy Jejunoileal (intestinal) bypass Cancer of the head, neck, or lung	Chronic malabsorption syndromes (i.e. Crohn's or ulcerative colitis) Pulmonary fibrotic lesions on chest x-ray	Abnormal immune system (including HIV/AIDS, cancer chemotherapy, etc.) Prolonged corticosteroid therapy (e.g. Prednisone 15mg/daily or more for 1 month) or other immunosuppressive treatment

6. In the last 5 years, have you worked, lived or volunteered in a hospital or other healthcare facility, homeless shelter, prison, nursing home, or HIV/AIDS clinic in a capacity where you had contact with patients and/or residents? **IF "YES", follow Instruction Set "A" below.**	**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 "A" below.**	**YES**	**NO**

IF YOU ANSWERED "NO" TO ALL OF THE QUESTIONS ABOVE, YOUR TUBERCULOSIS REQUIREMENT IS COMPLETE.

INSTRUCTION SET A: 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:

- **TB skin test (PPD):** Healthcare provider must supply date placed, date read and result in mm induration.
- **Interferon-Gamma Release Assay (IGRA):** Includes QuantiFERON® TB Gold or T-SPOT blood tests. A copy of the lab report must be attached.

PLEASE NOTE: If PPD result is >= 10mm or the blood test is positive; you are also required to follow **INSTRUCTION SET B** below.

INSTRUCTION SET B: You are required to **1)** submit a report from a Chest X-Ray performed **in the USA**, and **within 6 months** prior to entrance into Northwestern, and **2)** if treated for tuberculosis, **a copy of any treatment, including medications and dates of treatment** to the Evanston Campus Health Service. Upon arrival to campus and after class registration is complete, you will also be required to meet with a Health Service physician.

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. After arriving on campus, please call the Health Service at 847-491-2204 to schedule an appointment. **TB tests & Chest X-Rays from other countries will NOT be accepted and <u>will be repeated at the student's expense</u>.**

PART IV: HEALTH HISTORY

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

Student Name: _____ **Student ID:** _____ **Date of Birth:** _____

Personal Health History

PLEASE CHECK YES OR NO (Y/N), PROVIDING SPECIFIC DETAILS TO ALL" YES" ITEMS TO THE BEST OF YOUR KNOWLEDGE.

Y	N	ITEM	DETAILS (list specific information)
		Allergies (any)	
		Will you be receiving allergy shots at NU?	If you answer "Yes", please refer to the following link to print additional required forms: http://www.northwestern.edu/healthservice-evanston/medical-services/allergy-shots/index.html
		Adverse Medication Reaction	
		Current medications (prescription or other) If so, list frequency and length of time taken.	

ITEM	Y	N	YEAR	Check each item:	Y	N	YEAR
Alcohol or drug problems				Epilepsy/Seizure Disorder			
Appendectomy				Fractures/Broken Bones			
Asthma				Heart condition, disease, or murmur			
Attention Deficit/Hyperactivity Disorder				HIV test Positive or AIDS			
Cancer, leukemia, or lymphoma				High Blood Pressure			
Chicken Pox/Varicella				Migraine Headaches			
Cholesterol or lipid problems				Mononucleosis/Epstein-Barr Virus			
Concussion/Mild Traumatic Brain Injury				Sexually Transmitted Diseases			
Depression or Anxiety (specify)				Splenectomy			
Diabetes Mellitus				Tonsillectomy			
Eating Disorder/Anorexia/Bulimia				Transfusion of blood/blood product			
Emotional/Psychological problems				Viral Hepatitis (specify, e.g. A, B, C)			

Other surgical/medical condition not listed: _____

Family Health History

PLEASE CHECK YES OR NO (Y/N). Indicate relationship as follows for "Yes" items: **F**=Father, **M**=Mother, **B**=Brother, **S**=Sister

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

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: _____