



WILMINGTON

UNIVERSITY
COLLEGE OF HEALTH
PROFESSIONS

Please Email **Completed** form to the following **2** Recipients:

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Wilmington University

Report of Health History

Both sides of this form MUST be completed.

MSN

BSN

ALH

Male Female

Last Name

First Name

Middle

Home Address

City

State

Zip

Home Telephone Number

Work Telephone Number

Cell Telephone Number

Email Address

Name of 2 Emergency Contact Persons

Relationship to Student

Telephone

Statement of Health Status:

This information will only be used for the intent of assisting the student in pursuit of an undergraduate degree. Providing the information is voluntary and will be kept confidential. Please check one of the two choices and sign below.

I am in satisfactory health and believe I will be able to manage all requirements of the program in which I enrolled without special accommodations.

I may require special accommodations to complete some aspects of the program. If so, I understand that it is the student's responsibility to contact the Office of Student Affairs .

Signature

Date

(If electronic, I agree that my e-signature is equivalent to my manual signature.)

Printed Name

Please note: This document will only be accepted if completed in full per the response indicated. If the fields are not correctly noted, the form will be returned to the student for further clarification and attention.

Wilmington University

IMMUNIZATION AND SCREENING HEALTH STATUS

The following documentation is required for all MSN, BSN & ALH students per Wilmington University policy and in accordance with current Centers for Disease Control (CDC) Recommendations for HealthCare Providers, encompassing the College of Health Professions student population.

Check the appropriate immunity history:

- Born prior to 01/01/1957. No further documentation of Measles, Mumps, Rubella (MMR) required. **Please continue in completing the Varicella, Hep B, TB Screening, & Influenza.**
- Born after 01/01/1957. **Complete the MMR history and remaining fields as noted below.**

DISEASE	VACCINE ADMINISTERED/ DATE	TITER CONFIRMATION OF SEROLOGIC IMMUNITY (attach lab report and record date)	HAD THE DISEASE
MEASLES (Rubeola)	DOSE 1 of live vaccine: (at 12 months after birth or later): date: DOSE 2 (after 1980): date:	date: <input type="checkbox"/> Presence of IgG Antibody \geq 1:8	
MUMPS	Live vaccine (at 12 months after birth or later): date:	date: <input type="checkbox"/> Presence of IgG Antibody \geq 1:16	
RUBELLA (German Measles)	Live vaccine (at 12 months after birth or later): date:	date: <input type="checkbox"/> Presence of IgG Antibody \geq 10 IU/mL	
VARICELLA (Chicken Pox)	DOSE 1: date: DOSE 2: date:	date: <input type="checkbox"/> Positive IgG indicates immunity	
HEPATITIS B IMMUNIZATION (three required doses)	DOSE #1: date:	DOSE #2: date:	DOSE #3: date:
	<input type="checkbox"/> DECLINED		
Hep B Results confirmed: <input type="checkbox"/> HBsAg negative <input type="checkbox"/> AntiHBs positive			
TUBERCULOSIS (TB) Screening (required within one year)	TST (Mantoux Tuberculin Skin Test or PPD) Date Read: Result #1: (attach results) <input type="checkbox"/> LTBI (Latent TB Infection): PPD \geq 5mm <input type="checkbox"/> CXR date:		
INFLUENZA	Date:	<input type="checkbox"/> DECLINED – I understand if I did not get the vaccine, I may not be able to attend my selected Clinical Site per their institutional policy and requirements.	

Signature of health care provider (HCP)

Printed name of health care provider (HCP)

(If electronic, I agree that my e-signature is equivalent to my manual signature.)

Date

*** Documentation with the results highlighted may be attached to this form in lieu of HCP signature.**

Health History Reviewed & Results Confirmed by COHP Faculty: Initials ,RN date
