WILMINGTON UNIVERSITY

COLLEGE OF HEALTH PROFESSIONS

1.) Please Email **Completed** form (Federal/Admissions requirement):

Undergraduate Admissions
Wilmington University
Fax – (302)-328-5902
leslie.a.clark@wilmu.edu

2.) Students should **retain** a copy of their completed health history form for future submission (upload) to Verified Credentials online documentation portfolio (College of Health Professions requirement).
For questions about the Verified Credentials process or program specific information please contact the College of Health Professions.

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

<u>Please note:</u> ***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: ☐ Presence of IgG Antibody ≥ 1:8	
MUMPS	Live vaccine (at 12 months after birth or later): date:	date: ☐ Presence of IgG Antibody ≥ 1:16	
RUBELLA (German Measles)	Live vaccine (at 12 months after birth or later): date:	date: ☐ Presence of IgG Antibody ≥ 10 IU/mL	
VARICELLA (Chicken Pox)	DOSE 1: date: DOSE 2: date:	date: ☐ Positive IgG indicates immunity	

HEPATITIS B IMMUNIZATION (three required doses)	DOSE #1: date:	DOSE #2: date:	DOSE #3: date:	☐ DECLINED
	Hep B Results confirmed: ☐ HBsAg negative ☐ AntiHBs positive			
TUBERCULOSIS (TB) Screening (required within one year)	TST (Mantoux Tuberculin Skin Test or PPD) Date Read: Result #1: (attach results) ☐ LTBI (Latent TB Infection): PPD ≥ 5mm ☐ CXR date:			
INFLUENZA	Date:	☐ 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