WILMINGTON UNIVERSITY™

HEALTH PROFESSIONS

1.) Please send **Completed** form by mail, email or fax (Federal/ Admissions requirement):

Attn: **Undergraduate Admissions**

320 N Dupont Highway

New Castle, DE 19720

Wilmington University Fax: 302-328-5902

Email: Leslie.a.clark@wilmu.edu

2. Students should **RETAIN A COPY** of their completed health history form for future submission (upload) to American Data Bank online documentation portfolio (College of Health Professions requirement).

For questions about the American Data Bank process or program specific information please contact the College of Health Professions.

Report of Health History

Both sides of this form should be completed. ☐ **HSC** ☐ **BSN** ☐ **MSN** ☐ **DNP**

☐ **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 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

IMMUNIZATION AND SCREENING HEALTH STATUS

The following documentation is required for all COHP students per Wilmington University policy and in accordance with current Centers for Disease Control (CDC) Recommendations for HealthCare Providers.

Check the appropriate immunity history:

☐ Born prior to 01/01/1957. No further documentation of Measles, Mumps, Rubella (MMR) required. Please continue in completing remaining fields as noted below.

☐ 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)	
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**	
			HAD DISEASE
VARICELLA (Chicken Pox)	**DOSE 1**: **date:** **DOSE 2: date:**	**date:** ☐ **Positive IgG indicates immunity**	☐ **(upload proof from provider)**
HEPATITIS B IMMUNIZATION (three required doses)	**DOSE #1: date:**	**DOSE #2: date:**	**DOSE #3: date:**
	Hep B Results confirmed: ☐ **HBsAg negative** ☐ **Anti-HBs positive**		
Tdap **Td**	**DOSE date:** **DOSE date:**		
TUBERCULOSIS (TB) Screening (required within one year)	**TST (Mantoux Tuberculin Skin Test or PPD) (2 STEP: 1-3 weeks apart)** **Date Read: Result #1:** **Date Read: Result #2:** ☐ **LTBI (Latent TB Infection): PPD ≥ 5mm** ☐ **CXR date: (Upload results)** ☐ **Quantiferon Gold test (upload results)**		
INFLUENZA- Current flu season- Sep-April	**Date:**	**Physician waiver required for any expectations** I understand if I did not get the vaccine I may be required per Clinical Site Policy to wear a mask at all times throughout flu season for the safety of patients.	

Signature of health care provider (HCP) **Printed name of health care provider (HCP)** **Date**

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