Office of the Vice Provost for Health

301 Michigan St. NE · Grand Rapids, MI 49503 · Ofc. 616.331.5812 · Fax 616.331.5640

Health and Immunization Form

Part I. Student Demographic and Emergency Contact Information

Name: ____

Last *First* *D.O.B*

Address: ____

Street *City/State* *Zip Code*

Phone: (   ) ______________________________ Student G#: ____________________

Emergency Contact: ____Relationship: _______________________

Address: ____

Street *City/State* *Zip Code*

Phone: (   ) ____

Part II. Immunization Documentation - Month/Day/Year

MMR (Measles, Mumps, Rubella) immunization dates **OR** positive titer results:

Immunization dates: #1 ___/___/____ Immunization date #2___/___/____ **OR**

Date MMR titer drawn: ___/___/____ **Lab result must be submitted**

Td or Tdap (Tetanus and Diphtheria or Tetanus, Diphtheria and Acellular Pertussis) immunization dates:

Td:___/___/____ or Tdap:___/___/____ Within the last 10 years

- **Must include date of last Tdap after age 11:___/___/____**

Hepatitis B immunizations dates (series of 3 immunizations) AND Hepatitis B surface antibody titer result:

Immunization dates: #1___/___/____ #2___/___/____ #3___/___/____ **AND**

Date Hepatitis B surface antibody titer drawn:___/___/____ **Lab result must be submitted**

Dates of additional immunizations: #1___/___/____ #2___/___/____ #3___/___/____

Varicella immunizations dates **OR** date of chicken pox disease **OR** positive varicella titer:

Varicella immunization dates: #1___/___/____ #2___/___/____

Date of Varicella disease:___/___/____

Date Varicella titer drawn:___/___/____ **Lab result must be submitted**

Influenza date of last immunization: ___/___/____

Required for Medical Laboratory Science Program only:

Meningococcal immunization within the last 5 years: ___/___/____

Part III. Tuberculosis (TB) Screening, Two-step Skin Test or Quantiferon Gold/T-Spot Test

A two-step TB skin test or Quantiferon-Gold/T-Spot test is required, unless history of a positive tuberculin test. The first TB skin test must be documented as "negative" and that it was completed within the past 12 months, the second TB skin test must be completed no earlier than 7 days after the first.

TB skin test #1 Date placed:___/___/____ Date read:___/___/____ Result: ______mm Read by: ____________
TB skin test #2 Date placed:___/___/____ Date read:___/___/____ Result: ______mm Read by: ____________

OR Quantiferon-Gold/T-Spot test (used instead of the two skin tests)
Date of test:___/___/____ **Lab result must be submitted**

OR if positive TB test **OR** individual with history of a positive TB test:
Date of baseline chest x-ray: ___/___/____ X-ray results: ________________ **X-ray report must be submitted**

Date of TB symptom review: ___/___/____ Is individual free of signs and symptoms of TB? ____________

Part IV. Review of Essential Functions and Technical Standards (See Attachment)

Only required for the following programs of study: Athletic Training, Nursing, Medical Laboratory Science, Occupational Therapy, Physical Therapy and Physician Assistant.

Part V. Physical Exam and Verification

I have obtained a health history, performed a physical exam, and have reviewed the program essential functions and/or technical standards (if required for this individual's program). Please initial your response: ____Yes ____No

In my opinion this individual is mentally and physically capable of full participation in their designated program.

Please initial your response: _____Yes______No

If this individual is NOT capable to fully participate please comment on limitations: ___________________________
____
____

Part VI. Healthcare Provider Information

Health Care Provider: ___________________________________ Office: _____________________________________
(Please Print)
Signature: ____Date: _____/_____/_____

Address: ____
Street *City/State* *Zip Code*

Phone: ( ) ____

Student Name: ____ D.O.B ___/___/____ G #_______________________