Washington University in St.Louis

Dear New WUSM Student:

Congratulations on your acceptance! We look forward to meeting you and working with you to achieve optimal health as you pursue academic success. Our mission at Student Health Service is to deliver efficient, accessible, high-quality medical care, without undue financial burden, in order to prevent and treat health problems that may interfere with your education and professional goals while attending WUSM.

One of our responsibilities is to ensure that each matriculating student complies with CDC recommendations for a health care provider as well as the university and affiliated teaching hospitals health requirements. As part of your onboarding, your immunization records and history will be reviewed in relation to your program duties.

There are 3 Health-related Requirements at WUSM:

1. Immunization dates
2. Proof of immunity
3. Physical (within 1 year of matriculation)

To meet these Requirements:

1) Please review the enclosed instructions and complete the forms provided. Forms A & B must be completed on-line using the Student Health electronic record submission in accordance with the deadlines mentioned below.
2) Form A & B; health history and immunity history is required to be completed online. This information will help us provide you care while here.
3) For assistance download forms B & C and take with you to your health care provider who can ensure you have all the required vaccinations, proof of immunity and a physical with 1 year of matriculation.

   Please note: form B is your immunity history and is to be used as a worksheet ONLY. You must submit written, authentic documentation to support the immunization dates. (i.e. immunization record from a physician's office, school, public health department, etc.)

4) Using your WUSTL key log into the Student Health electronic record submission and enter forms A and B. All other required documents scan and email a PDF copy to Studenthealthservice@wusm.wustl.edu.

Deadlines:

1. Summer matriculation - 1 month prior to school starting
2. Fall matriculation - July 15th

If you have any questions or need any assistance with the deadlines, please contact us at 314-362-3523 or StudentHealthService@wusm.wustl.edu.

Again, please accept our warm welcome as well as our best wishes for your success!

Washington University in St.Louis

Student Health Service

Email: StudentHealthService@wusm.wustl.edu
(314) 362-3523 Fax (314) 362-0058
660 S. Euclid • Box 8030 • St. Louis, MO 63110

Office use only

This record is required, is kept in confidence, and has no bearing on your academic status.
Please fill in the personal history completely and legibly.
This will become part of your confidential health record while at
Washington University and will be kept in your personal health folder.

Please Print

Last Name: _____ First Name: _____ Mi: _____

Date of Birth: _____ Place of Birth: _____ Gender At Birth: _____

WUSTL E-mail: _____

Please supply your St. Louis Address ONLY

Street: _____ City: _____ State: _____ Zip: _____

Phone Number _____ Campus Telephone: _____

Marital Status

Name of Previous College: _____

Years of attendance: _____

Parent, Guardian, Spouse: Emergency Contact

Name: _____ Relation: _____

Address: Street: _____ City: _____ State Zip _____

Phone Number

Are you covered by private insurance? ☐ **Yes** ☐ **No**

If yes, name of company: _____

Policy/Group Number _____

Expiration date: _____

Student Health is always secondary with private insurance. http://wusmhealth.wustl.edu

Program in Which You Will Enroll

☐ Medical ☐ Medical Scientist Training Program
☐ Occupational Therapy ☐ Physical Therapy
☐ Graduate, Biomedical Science
☐ PACS • Program length: _____
☐ Other: _____ ☐ Spouse/Dependent

Date starting school

- Have you been hospitalized within 10 years: ☐ Yes ☐ No

If yes, indicate when, where, and why in the space below.

- Have you had surgery within 5 years? ☐ Yes ☐ No

If yes, indicate when, where, and why in the space below.

- Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, indicate why in the space below.

- Are you now being treated for any mental and/or physical illness? ☐ Yes ☐ No

If yes, indicate the condition and forms of therapy in the space below.

- Have you ever been diagnosed with Hepatitis B? ☐ Yes ☐ No
- Have you ever been diagnosed with Hepatitis C? ☐ Yes ☐ No
- Have you ever been diagnosed with HIV? ☐ Yes ☐ No
- Tobacco use? ☐ Yes ☐ No If yes, please describe use _____
- Alcohol use? ☐ Yes ☐ No If yes, please describe use _____

Comments:

_____

_____

_____

_____

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things.	☐	☐	☐	☐
Feeling down, depressed or hopeless	☐	☐	☐	☐

Are you allergic to penicillin? ☐ Yes ☐ No

to sulfa? ☐ Yes ☐ No

to other drugs? ☐ Yes ☐ No

if yes, to what drug(s):_____

Please list any medication you are currently taking: (**Please ensure you arrive with 1 -2 month supply of medication.)**

_____

_____

_____

_____

If you have a medical problem that may require continued medical supervision, please authorize your physician to forward relevant information to:

Student Health Service
Washington University Medical School
660 S. Euclid Ave, Box 8030
St. Louis, MO 63110
Phone: (314) 362-3523
Fax: (314) 362-0058

As the person signing this consent, I understand that I am giving Student Health Service my permission to communicate protected health information as defined under the HIPAA or FERPA. I understand that I have the right to revoke this authorization at any time. My revocation must be in writing. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from Student Health Service, or will it affect my eligibility for benefits.

I hereby give WUSM Student Health Service my permission to transmit communications to me via E-mail, and/or call me at the listed telephone number leaving a voicemail when unavailable. We want to make sure you know that unencrypted email is not a secure means of communication and we will encrypt our email communications to you unless you tell that you prefer us to use unencrypted email.

Voicemail may be used: □ Yes □ No

Telephone number that may be used:_____

Unencrypted E-mail may be used: □ Yes □ No
Authorized E-mail: _____

_____ _____
Student's Signature Date

Washington University in St.Louis

Student Health Service Immunity Form

Name: _____
(Last) (First) (Mi)

Date of Birth_____ Student ID _____

(Must be completed *PRIOR* to ARRIVAL)

Non-compliant students will be excluded from classroom and/or patient care areas.

Tuberculosis Testing: Must have a 2 step Tuberculin (TB) skin test **or** one Interferon-Gamma Release Assays (IGRA) (T-Spot) or (QFT) within 3 months of the incoming student deadline.

Have you had a positive Interferon-Gamma Release Assays (IGRA)? ☐Yes ☐No

If yes – Chest X-ray (must be after the positive test result) _____ Result_____ Email copy of report_____

If treatment taken: ☐INH or ☐Rifampin or other (check one)

Duration of therapy ___-___-___ to ___-___-___.

Have you had a positive TB skin test measured 10mm or larger ☐Yes ☐No

- Did you take treatment? Yes____ No_____
- Chest X-ray (must be after the positive result) _____ Result_____ Attach copy of report_____
- If treatment taken: INH or Rifampin or other (check one)
- Duration of therapy ___-___-___ to ___-___-___. Email documentation of your positive test result and treatment record.

Tuberculosis Testing: You must have a 2 step Tuberculin (TB) skin test or IGRA blood test for Tuberculosis (T-spot or QFT) within 3 months of starting school.

#1 - TB skin test Date Read: _____ Result: _____mm. The first test must be within the past 12 months.
- If this test is negative less than 10mm then will need a 2nd TB skin test at least 1 week apart and within 3 months of starting school.
- If test is positive greater than 10mm then you will need to do the TB blood test, InterferonGamma Release Assays (IGRA)
- If IGRA test is negative then you are have completed the TB testing requirements.

#2 TB skin test Date Read: _____ Result: ___ mm. The 2nd TB test must be within 3 months of starting school and must be placed at least 1 week since the first TB test.
- If 2nd TB skin test is negative, less than 10mm, then you have completed TB testing.
- If test is positive, greater than 10mm, then you will need to do the TB blood test, InterferonGamma Release Assays (IGRA)

- If IGRA test is negative then you have completed the TB testing requirements.

- If the IGRA test is positive, then you will need to provide a chest x-ray report dated after the positive test result.

OR

Interferon-Gamma Release Assays (IGRA) test (T-spot or QFT.) if you elect to do the TB blood test (IGRA), T-spot or Quatiferon TB Gold are both acceptable. This must be done with 3 months of starting school. . Copy sent to Studenthealthservice@wusm.wustl.edu

T-Spot testing date collected: _____ Outcome: (-) = negative (+) = positive or QFT testing date collected:_____. Outcome: (-) = negative (+) = positive. Must supply copies of all laboratory testing.

Tetanus – Diphtheria – Pertussis (Tdap) **Written, authentic documentation of One dose of the adult Tdap in the past 10 years.**	***Date***
☐ **Tetanus-Diphtheria-Pertusiss (Tdap)** **(Adult booster must be within the last 10 years)**	

MMR **Written, authentic documentation of 2 MMR vaccines or 2 doses of Measles vaccine, 2 doses of Mumps vaccine and 1 dose of Rubella vaccine or Serologic proof of immunity for Measles, Mumps and Rubella.** Copy sent to Studenthealthservice@wusm.wustl.edu	***Date***
☐ MMR Vaccine #1 ☐ MMR Vaccine #2 OR ☐Measles vaccine #1 ☐Measles vaccine #2 ☐Mumps Vaccine #1 ☐Mumps Vaccine #2 ☐Rubella Vaccine #1	
OR **Written, authentic documentation of Serologic proof of immunity for Measles, Mumps and Rubella.** Copy sent to Studenthealthservice@wusm.wustl.edu	

Rubeola/Rubella/Mumps IgG antibodies/titer	Measles (Rubeola) IgG antibody Copy sent to Studenthealthservice@wusm.wustl.edu	
	Outcome ☐negative ☐ non-immune ☐ equivocal ☐ in eterminate	
	Outcome ☐ positive☐ immune	
	Rubella IgG antibody Copy sent to Studenthealthservice@wusm.wustl.edu	
	Outcome ☐ negative ☐ non-immune ☐ equivocal ☐ indeterminate	
	Outcome ☐ positive☐ immune	
	Mumps IgG antibody Copy sent to Studenthealthservice@wusm.wustl.edu	
	Outcome ☐ negative ☐ non-immune ☐ equivocal ☐ indeterminate	

	Outcome ☐ positive ☐ immune	
If **NEGATIVE** blood test results, must receive Re-immunization MMR vaccinations.	#3 MMR Re-immunization Date ***28 days apart*** #4 MMR Re-immunization Date	
Varicella (Chicken Pox) Written authentic documentation of 2 doses of Varicella vaccine. Copy sent to Studenthealthservice@wusm.wustl.edu **Or** Written authentic documentation of the laboratory evidence of immunity of a positive Varicella IgG antibody. Copy sent to Studenthealthservice@wusm.wustl.edu		Date
Varicella IgG antibody titer (must supply copy of laboratory report confirming immunity) or vaccination dates. History of illness not acceptable.	Varicella IgG antibody Copy sent to Studenthealthservice@wusm.wustl.edu	
	Outcome ☐ negative ☐ non-immune ☐ equivocal ☐ indeterminate	
	Outcome ☐ positive ☐ immune	
	OR	
	☐ Varivax #1	
	☐ Varivax #2	
Hepatitis B Documentation of 3 doses of the Hepatitis B vaccine **AND** positive Quantitative. You must include a copy of the lab report with your legal name.		***Date***
Hepatitis B Vaccine REQUIRED for Med, OT, PT and PACs programs. (Those who are in a hospital/clinic or patient care area, or who have direct contact with patients or research study participants	☐ Hepatitis B vaccine #1	
	☐ Hepatitis B vaccine #2	
	☐ Hepatitis B vaccine #3	
Hepatitis B surface antibody titer (must supply copy of laboratory report confirming immunity)	**REQUIRED** if completed series and enrolled in Med, OT, PT and PACs programs. ☐ Copy sent to Studenthealthservice@wusm.wustl.edu Outcome ☐ negative ☐ non-immune ☐ equivocal ☐ indeterminate	
Quantitative	Outcome ☐ positive ☐ immune	
If Hepatitis B Antibody Negative after having had the full 3 dose series, an additional Hepatitis B vaccine is needed. Retest the Hepatitis B antibody after 1 month of the additional dose. If Hepatitis B antibody still negative then complete remaining 2 doses of 2nd series.		
If negative Hepatitis B Surface Antibody) Hepatitis B #4 Copy sent to Studenthealthservice@wusm.wustl.edu		

Hepatitis B Vaccine #5 Copy sent to Studenthealthservice@wusm.wustl.edu	
Last dose of series is 3 to 6 months after 1st dose of this series. Hepatitis B Vaccine #6 Copy sent to Studenthealthservice@wusm.wustl.edu	
COVID -19	***Date***
Required to provide proof of full vaccination with an FDA-authorized or World Health Organization approved COVID-19 vaccine or an approved exemption.	
COVID – 19 #1 Primary series COVID – 19 #2 Primary series **OR** COVID – 19 Updated Vaccine	
ADDITIONAL VACCINES You may have already received, but are NOT required for entrance to the program	
Hepatitis A vaccine #1	
Hepatitis A vaccine #2	
Polio last booster	
☐ Menomune **or** ☐ Menactra	
HPV Vaccine #1	
HPV Vaccine #2	
HPV Vaccine #3	
Yellow Fever	
Typhoid ☐ oral ☐ injection	

This form is a worksheet only - must be completed on-line by July 15th for Fall Semester and 1 month prior to school starting for Summer Semester. All other required proof of immunity scan and email a PDF copy to Studenthealthservice@wusm.wustl.edu.

All new students must present a report of a physical examination done within twelve months prior to admission. ***Take this form along with the immunity (B) form to a clinic, your physician or your undergraduate Student Health Service for completion. Refer to the Immunity form for required labs – must supply copy of blood test results.***

Name:_____ Age:_____ Gender: _____

P_____ BP_____ Height_____ Weight_____

CLINICAL EVALUATION	NORMAL	ABNORMAL	Describe any abnormality
Enter "N.E." if not evaluated			
Skin, Scalp			
Scars			
Nutrition			
Musculature			
HEAD			
Eyes			
Ears			
Nose			
Teeth & Gingiva			
Tongue			
Tonsils			
Pharynx			
NECK			
Nodes			
Thyroid			
CHEST			
Lung Fields			
Heart			
ABDOMEN			
Organs			
Masses			
Hernia			
Date and Results of most recent PAP test			Date: _____ ☐COPY ATTACHED
EXTREMITIES			
Upper			
Lower			
SPINE			
REFLEXES			

Summary of Defects and Diagnoses:_____

_____

Recommendations: (for follow-up or treatment)_____

_____

Licensed Medical Professional Signature (MD, DO, PA, NP)

_____

Date of Examin

Provider stamp