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.

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 is your health history that is required to be completed online. This information will help us provide you care while here.
3) Take forms B & C 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 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!
Student Health History – Form A
This form must be completed on-line by July 15th for Fall Semester and 1 month prior to school starting for Summer Semester.

**Please Print**

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
<th>Mi:</th>
<th>Date of Birth:</th>
<th>Place of Birth:</th>
<th>Gender At Birth:</th>
</tr>
</thead>
</table>

WUSTL E-mail: __________________________

*Please supply your St. Louis Address ONLY*

<table>
<thead>
<tr>
<th>Street:</th>
<th>City:</th>
<th>State:</th>
<th>Zip:</th>
</tr>
</thead>
</table>

Phone Number: ________

Campus Telephone: ________

Marital Status: ________

Name of Previous College: __________________________

Years of attendance: __________________________

**Parent, Guardian, Spouse: Emergency Contact**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Relation:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address: Street:</th>
<th>City:</th>
<th>State</th>
<th>Zip:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Phone Number:</th>
<th></th>
</tr>
</thead>
</table>

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](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**

[ ] Medical [ ] Medical Scientist Training Program

[ ] Occupational Therapy [ ] Physical Therapy

[ ] Graduate, Biomedical Science

[ ] PACS • Program length: ________

[ ] Other: ________

[ ] Spouse/Dependent

[ ] Medical [ ] Medical Scientist Training Program

[ ] Occupational Therapy [ ] Physical Therapy

[ ] Graduate, Biomedical Science

[ ] PACS • Program length: ________

[ ] Other: ________

[ ] Spouse/Dependent
- 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?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little interest or pleasure in doing things</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling down, depressed or hopeless</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

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
Student Health Immunity – Form B
This form 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.

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 Interferon-Gamma Release Assays (IGRA) (T-Spot) or (QFT) within 3 months starting school.

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, Interferon-Gamma 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, Interferon-Gamma 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. PDF 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.

<table>
<thead>
<tr>
<th>Tetanus – Diphtheria – Pertussis (Tdap)</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Tdap (At least one dose REQUIRED in the past 10 years)</td>
<td></td>
</tr>
<tr>
<td>□ Tetanus-Diphtheria (TD) ( Booster)</td>
<td></td>
</tr>
</tbody>
</table>

**COVID -19**

We will follow CDC guidelines and accept vaccination with either an FDA or WHO approved EUA vaccine. The following vaccines currently meet this requirement: ● Pfizer (2 doses) ● Moderna (2 doses) ● Johnson & Johnson (1 dose) ● AstraZeneca (2 doses)

- □ COVID-19 Vaccine #1
- □ COVID-19 Vaccine #2

**MMR**

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. PDF Copy sent to Studenthealthservice@wusm.wustl.edu

☐ MMR Vaccine #1
☐ MMR Vaccine #2
☐ Measles vaccine #1
☐ Measles vaccine #2
☐ Mumps Vaccine #1
☐ Mumps Vaccine #2
☐ Rubella Vaccine #1

OR

**Documentation of Serologic proof of immunity for Measles, Mumps and Rubella. PDF copy sent to Studenthealthservice@wusm.wustl.edu**

<table>
<thead>
<tr>
<th>Rubeola/Rubella/Mumps IgG antibodies/titer</th>
<th>Measles (Rubeola) IgG antibody</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles (Rubeola) IgG antibody</td>
<td>PDF copy sent to <a href="mailto:Studenthealthservice@wusm.wustl.edu">Studenthealthservice@wusm.wustl.edu</a></td>
</tr>
<tr>
<td>Outcome □ negative □ non-immune □ equivocal □ indeterminate</td>
<td></td>
</tr>
</tbody>
</table>
Rubella IgG antibody  
PDF copy sent to Studenthealthservice@wusm.wustl.edu

Outcome □ positive □ immune
Nonimmune □ non-immune □ equivocal □ indeterminate

Mumps IgG antibody  
PDF copy sent to Studenthealthservice@wusm.wustl.edu

Outcome □ positive □ immune
Nonimmune □ non-immune □ equivocal □ indeterminate

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)  
Documentation of 2 doses of Varicella vaccine. PDF copy sent to Studenthealthservice@wusm.wustl.edu

Or

copy of the lab result of a positive Varicella IgG antibody. PDF copy sent to Studenthealthservice@wusm.wustl.edu

Varicella IgG antibody titer (must supply copy of laboratory report confirming immunity) or vaccination dates. History of illness not acceptable.

Varicella IgG antibody  
PDF copy sent to Studenthealthservice@wusm.wustl.edu

Outcome □ negative □ non-immune □ equivocal □ indeterminate

OR

Varivax #1
Varivax #2

Hepatitis B  
Documentation of 3 doses of the Hepatitis B vaccine AND positive Quantitative Hepatitis B Surface antibody. You must include a copy of the lab report.

Hepatitis B Vaccine REQUIRED for Med, OT, PT and PACs programs.

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.

PDF 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 1 month after 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**

PDF copy sent to [Studenthealthservice@wusm.wustl.edu](mailto:Studenthealthservice@wusm.wustl.edu)

**Hepatitis B Vaccine #5**

PDF copy sent to [Studenthealthservice@wusm.wustl.edu](mailto:Studenthealthservice@wusm.wustl.edu)

Last dose of series is 3 to 6 months after 1<sup>st</sup> dose of this series.

**Hepatitis B Vaccine #6**

PDF copy sent to [Studenthealthservice@wusm.wustl.edu](mailto:Studenthealthservice@wusm.wustl.edu)

### ADDITIONAL VACCINES

You may have already received, but are NOT required for entrance to the program

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Date</th>
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<tbody>
<tr>
<td>Hepatitis A vaccine #1</td>
<td></td>
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<tr>
<td>Hepatitis A vaccine #2</td>
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<tr>
<td>Polio last booster</td>
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<tr>
<td>Menomune □ □ Menactra</td>
<td></td>
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<tr>
<td>HPV Vaccine #1</td>
<td></td>
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<tr>
<td>HPV Vaccine #2</td>
<td></td>
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<tr>
<td>HPV Vaccine #3</td>
<td></td>
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<tr>
<td>Yellow Fever</td>
<td></td>
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<tr>
<td>Typhoid □ □ oral □ injection</td>
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</table>
Student Health Physical – Form C
These forms must be completed July 15th for Fall Semester and 1 month prior to school starting for Summer Semester. All students must present a report of a physical examination done within twelve months prior to admission. **Take this form along with the immunity 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. Scan and email a PDF copy to Studenthealthservice@wusm.wustl.edu.

Name:______________________________________ Age:______ Gender: _____________
P_________ BP_____ Height_______ Weight_______

<table>
<thead>
<tr>
<th>CLINICAL EVALUATION</th>
<th>NORMAL</th>
<th>ABNORMAL</th>
<th>Describe any abnormality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter “N.E.” if not evaluated</td>
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<tr>
<td>Skin, Scalp</td>
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<tr>
<td>Scars</td>
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<td>Nutrition</td>
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<td>Musculature</td>
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<td><strong>HEAD</strong></td>
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<td>Eyes</td>
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<td>Ears</td>
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<tr>
<td>Nose</td>
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<tr>
<td>Teeth &amp; Gingiva</td>
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<tr>
<td>Tongue</td>
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<tr>
<td>Tonsils</td>
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<tr>
<td>Pharynx</td>
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<td><strong>NECK</strong></td>
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<tr>
<td>Nodes</td>
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<tr>
<td>Thyroid</td>
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<tr>
<td><strong>CHEST</strong></td>
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<td>Lung Fields</td>
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<td>Heart</td>
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<tr>
<td>Breasts</td>
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<tr>
<td><strong>ABDOMEN</strong></td>
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<tr>
<td>Organs</td>
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<tr>
<td>Masses</td>
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<tr>
<td>Hernia</td>
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<tr>
<td><strong>RECTAL</strong></td>
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<tr>
<td><strong>GENITALIA</strong></td>
<td></td>
<td></td>
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<tr>
<td>Date and Results of last PAP test</td>
<td>Date: __________________</td>
<td>COPY ATTACHED</td>
<td></td>
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<tr>
<td><strong>EXTREMITIES</strong></td>
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<tr>
<td>Upper</td>
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<tr>
<td>Lower</td>
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<tr>
<td><strong>SPINE</strong></td>
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</tbody>
</table>
REFLEXES

Summary of Defects and Diagnoses: ____________________________________________

_____________________________________________________________________________

Recommendations: (for follow-up or treatment) ______________________________________

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

______________________________________________

Date of Exam  

Provider stamp