

Student's Name: _____

Medical History—Personal: Please check if you have or have had any of the following:

Have you had or do you currently have:	Yes	No		Yes	No		Yes	No		Yes	No
ADD/ADHD			Drug/alcohol abuse			Mononucleosis			Tuberculosis		
Anemia			Ear/nose/throat conditions			Mumps			Urinary tract infections		
Anxiety			Eating disorder			Pneumonia			Weakness: paralysis		
Asthma			Eye conditions			Recurrent headaches/migraines			Weight gain/loss		
Back pain			Frequent indigestion			Seizure disorder			Other conditions:		
Cancer			Gallbladder disease			Sexually transmitted infection					
Chest pain/pressure			Head injury/concussion			Shortness of breath					
Chicken pox			Heart murmur			Sickle cell trait					
Chronic cough			Heart palpitation			Sinusitis			Female students:		
Depression			High/low blood pressure			Sleeping difficulty			Irregular periods		
Diabetes			Jaundice/Hepatitis			Stomach/intestinal/ulcer issues			Pregnancy		
Dizziness/fainting			Joint injury			Thyroid disorder			Severe cramps		

Please explain any "yes" answers in the Personal Medical History:

	Yes	No	Comments
Have you had any illness/injury or surgery which required hospitalization?			
At any time, have any of your activities been restricted due to illness, injury, etc.? Please explain if yes.			
Have you ever experienced any personal or emotional difficulties that required professional attention or hospitalization?			If you would like more information about mental health services you may contact Drake Counseling Center at 515-271-3864.
Please list any medications you are currently taking:			
Please list any allergies and reactions to include medications, food, and environmental:			

Drake University Student Health Immunization History

Obtain copies of your immunization records and attach to this form.

Examples of acceptable documents include:

- Copies of physician office or health department immunization records
- Copies of high school or previous college immunization records

(Please fill in the dates below.)

Student Name: _____ DOB: _____

Required immunizations

MMR (Measles, Mumps, Rubella) - 2 DOSES REQUIRED:

Proof of immunity to MMR is a requirement for registration for classes. This requirement is fulfilled if you meet one of the following criteria:

- birth date before 1957
- **or** received two doses of MMR vaccine (provide both dates)
1: ____/____/____ 2: ____/____/____
second dose must be at least 28 days after first dose.
- **or** received two doses of Measles, Mumps, Rubella vaccine (provide both dates)
Measles 1: ____/____/____ 2: ____/____/____
Mumps 1: ____/____/____ 2: ____/____/____
Rubella 1: ____/____/____ 2: ____/____/____
- **or** provide to Student Health Services copies of original lab reports of MMR titers that verify immunity to these diseases

Recommended Immunizations (but not required)

Tetanus/Diphtheria/Pertussis (TDAP):

Booster (within past 10 years): _____

Varicella: (birth in the U.S. before 1980, a history of chicken pox, a positive varicella antibody, or two doses of vaccine meets requirement)

History of the disease: ____ Yes ____ No

Immunization: Dose 1: ____ Dose 2: ____

Hepatitis B Series:

Dose 1: ____ Dose 2: ____ Dose 3: ____

Hepatitis A Series:

Dose 1: ____ Dose 2: ____

Gardisal (HPV vaccine):

Dose 1: ____ Dose 2: ____ Dose 3: ____

Strongly Recommended if Living on Campus

Meningitis (Menactra):

Meningitis is an infection of the fluid surrounding the brain and spinal cord that is caused by a virus or bacteria. Bacterial meningitis can be severe and cause organ damage and death. **The Meningitis vaccine is recommended for college freshmen living in residence halls.**

To make an informed decision about receiving the vaccine it is important to read the information provided at the following websites:

www.cdc.gov/vaccines/hcp/vis/vis-statements/mening.html
or
www.acha.org/topics/meningitis.cfm

Dose 1: ____

Dose 2: ____ (if Dose 1 was given before age 16)

If you have **not** received the meningitis vaccine you may sign a waiver: I am 18 years of age or older or the parent of a minor child. Drake University has provided me information explaining the risks of meningococcal disease and I am aware of the effectiveness and availability of the vaccine. I do not choose to get the meningococcal vaccine at this time.

Signature of student or parent/guardian

Date

To validate this form, have it signed and dated by your health care provider or authorized immunization official or provide a copy of your immunization record.

Name of Health Care Provider: _____ Signature: _____

Address: _____ Date (month/day/year): ____/____/____

Drake University Student Health Center Tuberculosis Screening Form

Patient Name: _____ Phone: _____

DOB: _____

All students are required to complete the below questionnaire.

Students from countries that have a high incidence of TB disease are required to have a TB skin test upon arrival at Drake University.

Check any that may apply:

- ____ Were you born in a high risk Country?
- ____ Have you lived in a high risk Country for more than 8 weeks? (See page 5 for list)
- ____ Have been diagnosed with a chronic medical condition that may impair your immune system
- ____ A health care worker/volunteer in a nursing home, prison, residential institution, or hospital
- ____ Have symptoms of active tuberculosis: unexplained weight loss or weakness, coughing up blood, night sweats
- ____ Contact with a person known to have active tuberculosis
- ____ Productive cough for more than two weeks
- ____ (If any of the above apply TB screening is required)
- ____ **None of the above apply (no TB test required)**

Attention international students:

- **DO NOT HAVE A TUBERCULOSIS SKIN OR BLOOD TEST DONE PRIOR TO COMING TO THE UNITED STATES. ALL TB SCREENING MUST BE DONE IN THE UNITED STATES.**
- Do not have a BCG vaccination prior to coming to Drake University.
- If you are required to have a chest x-ray, it must be done in the United States within one month of starting at Drake University.
- If you have had a positive TB skin test **OR** have been treated for TB infection or disease, bring a copy of your treatment report written in English.

Date: _____ Time: _____

PPD 0.1 ml administered on the ____ forearm.

Manufacturer: _____ Lot No.: _____ Expires: _____

Staff Signature: _____

The test must be observed 48 to 72 hours after being administered by an approved medical professional familiar with reading and recording test results.

PPD Read on: _____ Time: _____

Results are of ____ mm in duration.

Read by: _____

High Burden TB Country List 2020

(Countries with TB incidence rates of $\geq 20/100,000$ population)

Data obtained from 2019 WHO Global Tuberculosis Report and reflects 2018 data

Country	Country	Country	Country
Afghanistan	Dominican Republic	Madagascar	Sao Tome and Principe
Algeria	Ecuador	Malawi	Senegal
Angola	El Salvador	Malaysia	Serbia
Anguilla	Equatorial Guinea	Maldives	Sierra Leone
Argentina	Eritrea	Mali	Singapore
Armenia	Eswatini (formerly Swaziland)	Marshall Islands	Solomon Islands
Azerbaijan	Ethiopia	Mauritania	Somalia
Bangladesh	Fiji	Mexico	South Africa
Bangladesh	French Polynesia	Micronesia (Federated States of)	South Sudan
Belarus	Gabon	Moldova (Republic of)	South Korea (Republic of Korea)
Belize	Gambia	Mongolia	Sri Lanka
Benin	Georgia	Morocco	Sudan
Bhutan	Ghana	Mozambique	Suriname
Bolivia	Greenland	Myanmar (Burma)	Tanzania (United Republic)
Bosnia and Herzegovina	Guam	Namibia	Tajikistan
Botswana	Guatemala	Nauru	Thailand
Brazil	Guinea	Nepal	Timor-Leste
Brunei Darussalam	Guinea-Bissau	Nicaragua	Togo
Bulgaria	Guyana	Niger	Tokelau
Burkina Faso	Haiti	Nigeria	Trinidad
Burundi	Honduras	Niue	Tunisia
Cabo Verde	India	Northern Mariana Islands	Turkmenistan
Cambodia	Indonesia	North Korea (Democratic People's Republic)	Tuvalu
Cameroon	Iraq	Pakistan	Uganda
Central African Republic	Kazakhstan	Palau	Ukraine
Chad	Kenya	Panama	Uruguay
China	Kiribati	Papua New Guinea	Uzbekistan
China, Hong Kong SAR	Kuwait	Paraguay	Vanuatu
China, Macao SAR	Kyrgyzstan	Peru	Venezuela
Colombia	Lao People's Democratic Republic	Philippines	Viet Nam
Comoros	Latvia	Portugal	Yemen
Congo	Lesotho	Qatar	Zambia
Cote d'Ivoire	Liberia	Romania	Zimbabwe
Democratic Republic of the Congo	Libya	Russian Federation	
Djibouti	Lithuania	Rwanda	

Persons from these countries should be screened for TB and TB infection. Persons from countries not found on this list should only be tested if symptomatic or if they have risk factors.

Updated 1/5/2020