UNIVERSITY OF MARYLAND
PRE-COLLEGE PROGRAMS IN UNDERGRADUATE STUDIES
Upward Bound
Upward Bound Math & Science
LIFT

4150 Campus Drive, Toll Physics Bldg Rm 4111
College Park, Maryland 20742
301.405.6776 TEL 301.314.9155 FAX

rev 01/16

MEDICAL CLEARANCE FORM

I, Dr. _____ , have examined_____
(name of student)

and I give him/her medical clearance for participation in the Summer Program offered by Pre-College Programs at the University of Maryland, College Park.

Physician: If the student is currently using any type of medication, please note below the reasons for its use and the administration procedure.

_____

_____

_____

_____

_____
Physician Name (print)

_____
Physician Signature

_____
Date

PART I -- STUDENT HEALTH HISTORY

-- To be completed by parent/guardian --

Student Name (Last, First, Middle)	Birth Date (Mo. Day Yr.)	Sex (M F)	School	Grade

Address (Number, Street, City, State, Zip)	Phone No.

Parent or Legal Guardian Names

Where do you usually take your child for medical care? Phone No.:

Name: Address:

When was the last time your child had a physical exam?

Month: Year:

Where do you usually take your child for dental care? Phone No.

Name: Address:

ASSESSMENT OF STUDENT HEALTH

To the best of your knowledge, does your child have a history of or any problems with the following. Please check yes or no.

	Yes	No	Comments
Birth Defects			
Prematurity			
Hospitalization (When, Where)			
Concussion (Head Injury)			
Surgery			
Lead Poisoning			
Eye or Vision Problems			
Ear Problem or Deafness			
Speech Problem			
Cerebral Palsy			
Meningitis			
Heart Problems			
Serious Allergic Reactions			
Allergies, (Food, Insects, Drugs, etc.)			
Behavior or Emotional Problem			
	Yes	**No**	**Comments**
Asthma			
Sickle Cell Disease			
Diabetes			
Seizures			
Bleeding Problems			
Limits on Activity			
Problem with Bladder			
Problem with Bowels			

Does your child take any medication(s)? ❑ Yes ❑ No

Name of Medication(s) _____

Parent or Legal Guardian Signature _____ Date _____

PART II -- STUDENT HEALTH ASSESSMENT / PHYSICAL EXAMINATION

-- To be completed by physician or certified nurse practitioner --

Student Name (Last, First, Middle)	Birth Date (Mo. Day Yr.)	Sex (M F)	School	Grade

Address (Number, Street, City, State, Zip)	Phone No.

1. Does this child have a health condition which may require EMERGENCY ACTION while he/she is at school: (e.g., seizure, insect sting, asthma, allergy, bleeding problem, diabetes, heart problem?) If yes, please DESCRIBE.

❑ No ❑ Yes _____

_____

2. Is the student on long-term medication? If yes, please DESCRIBE.

❑ No ❑ Yes _____

_____

(A Medication administration form must be completed for in-school administration.)

3. Is this child on long-term technology assistance?

❑ No ❑ Yes _____

(Please note specifics) _____

_____

4. Is there any evidence for concern in the areas listed below? Indicate the results of your examination by placing a 3 in the appropriate space.

CONCERN

Health Area	Yes	No	Not Evaluated	Health Area	Yes	No	Not Evaluated
Vision				Adjustment			
Hearing				Nutrition			
Speech/Language				Physical Illness/impairment			
Development				Immunodeficiency			
Attention Deficit/Hyperactivity				Lead Poisoning			
Scoliosis				Other			

REMARKS: (Please explain any "yes"; include recommendation for referral and treatment.)

_____

_____

_____

5. Should there be any restriction of physical activity in school? If so, specify nature and duration of restriction.

❑ No ❑ Yes _____

_____

6. Tuberculin Test: Results Type Date of last test	Blood Pressure Height Weight Date Taken
❑ Positive ❑ Negative	

If you would like to discuss this student's health with school or school health personnel, check title below

❑ Nurse assigned to school ❑ Teacher(s) ❑ Counselor ❑ Principal ❑ School Health Physician ❑ Other

(Student Name) _____ has had a complete physical examination and has

❑ no evident problem that may affect learning **OR** ❑ problems noted above.

Physician /Certified Nurse Practitioner (Type of Print)	Phone No.	Physician/Certified Nurse Practitioner (Signature)	Date

-- Additional Comments on Reverse Side --

Additional Comments:

University Health Center
University of Maryland
College Park, Maryland 20742
Immunization Information: (301) 314-8139
Mail to address above or Fax to: (301) 314-5234
(Cover sheet not required.)

UNIVERSITY HEALTH CENTER

For Health Center Use Only
UID# _____
Initials _____
MMR ❑ MEN ❑
Cleared _____ Prov _____

Immunization Record

Form is due at Orientation

Forms received after the first day of classes will be assessed a non-compliance fee.

SECTION A (REQUIRED): TO BE COMPLETED BY ALL STUDENTS. Print legibly in blue or black ink.

Name (Last) _____ (First) _____ (Middle) _____

University ID# _____ Date of Birth _____

Student Status: U.S. Citizen ❑ Permanent Resident ❑ International ❑ Country of Origin: _____

Address _____ Cell Phone _____

_____ Email Address _____

Parental Consent (for students under age 18) I give my permission for such diagnostic and therapeutic procedures as may be deemed necessary for my son/daughter until they turn 18. The Health Center will try to notify parents in the event of an emergency.

Signed _____ Relationship _____

SECTION B (REQUIRED): TO BE COMPLETED FOR ALL STUDENTS born after 1956.

All doses of measles, mumps, rubella (MMR) vaccines must be given after the 1st (first) birthday and after1967. History of disease not accepted.

MMR	Dose 1	Dose 2
	____/____/____ M D YYYY	____/____/____ M D YYYY

Serological confirmation of immunity accepted. Attach copy of lab results. (Must be in English.)

OR

	Dose 1	Dose 2
MEASLES (Rubeola):	____/____/____ M D YYYY	____/____/____ M D YYYY
MUMPS:	____/____/____ M D YYYY	____/____/____ M D YYYY
RUBELLA:	____/____/____ M D YYYY	____/____/____ M D YYYY

SECTION C (REQUIRED): TO BE COMPLETED BY ALL STUDENTS. TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE

All incoming students are required to complete this questionnaire.

Have you ever had a POSITIVE test for TB?	Have you ever been exposed to anyone with active TB?	Have you ever had TB?	Have you received the BCG* vaccine?	Have you ever taken INH/Rifampin** medication?
Yes ❑ No ❑	Yes ❑ No ❑	Yes ❑ No ❑	Yes ❑ No ❑	Yes ❑ No ❑

In the past year have you had any of the following symptoms for a period of time greater than six months?

Persistent Cough	Persistent Fever	Loss of Appetite	Night Sweats	Chest Pains
Yes ❑ No ❑	Yes ❑ No ❑	Yes ❑ No ❑	Yes ❑ No ❑	Yes ❑ No ❑

Coughing Up Blood	Shortness of Breath	Unexplained Weight Loss	Weakness or Fatigue	If "YES", explain:
Yes ❑ No ❑	Yes ❑ No ❑	Yes ❑ No ❑	Yes ❑ No ❑	

* BCG -not given in US
** INH (Isoniazid) or Rifampin -a medication for TB/Latent TB

SECTION D (Recommended immunizations for good health): Record other immunizations received.

	Chicken Pox/Varivax	Hepatitis A	Hepatitis B	HPV	Meningococcal Vaccine Menactra ❑ OR Menveo ❑ *Given after age 16 or within past 3 years	Td ❑ OR Tdap ❑ (Within 10 years)
Dose 1	____/____/____ M D YYYY	____/____/____ M D YYYY	____/____/____ M D YYYY	____/____/____ M D YYYY		
Dose 2	____/____/____ M D YYYY	____/____/____ M D YYYY	____/____/____ M D YYYY	____/____/____ M D YYYY	____/____/____ M D YYYY	____/____/____ M D YYYY
	History of disease accepted. Date:_____		____/____/____ M D YYYY	____/____/____ M D YYYY	OR Meningitis waiver: Section G	

Reminder: Complete Section C. FORM CONTINUES ON NEXT PAGE

Name (Last) _____ University ID# _____

SECTION E: INTERNATIONAL STUDENTS

If you are not from one of the countries listed below, you are required to complete this section.

Albania, Andorra, Antigua and Barbuda, Australia, Austria, Bahamas, Barbados, Belgium, Bermuda, British Virgin Islands, Canada, Chile, Cook Islands, Costa Rica, Cayman Islands, Cuba, Cyprus, Czech Republic, Denmark, Dominica, Egypt, Finland, France, French Polynesia, Germany, Greece, Grenada, Hungary, Iceland, Ireland, Israel, Italy, Jamaica, Jordan, Lebanon, Luxembourg, Malta, Mexico, Monaco, Netherlands, New Zealand, Norway, Oman, Puerto Rico, Saint Kitts and Nevis, San Marino, Saint Lucia, Samoa, Saudi Arabia, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tonga, Trinidad and Tobago, United Arab Emirates, United Kingdom, United States of America, West Bank and Gaza Strip. (Source: As identified by the World Health Organization (WHO) Global Health Observatory and the American College Health Association.)

Interferon-based Assay must have been performed within the last year.		
Interferon-based Assay TB Blood Test) (Quantiferon Gold Test or T-Spot)	Date	Result: Attach copy of Lab Report
Chest X-Ray Required if Quantiferon Gold Test or T-Spot is POSITIVE		
Chest X-Ray (Needed ***ONLY*** if TB Blood Test is POSITIVE)	Date	Result: Attach copy of Radiology Report (in English)

SECTION F (REQUIRED): PHYSICIAN SIGNATURE OR ACCEPTABLE DOCUMENTATION

Physicians: Complete sections B through F.

PHYSICIAN SIGNATURE _____ DATE _____

PHYSICIAN NAME (printed) _____ PHONE # _____

Acceptable Documentation in Lieu of Physician Signature

Copies of acceptable documentation should be attached to this form with Section A and C completed.

- A copy of your high school immunization record (in English)
- Personal immunization records (written in English) with your physician's signature. Digital copies are not accepted.
- Proof of current or previous active duty (DD214) status in the U.S. Military will be accepted.
- Copy of Lab Titer Report for Measles, Mumps, and Rubella
- International Certificate of Vaccination (in English), reflecting the information required in Section B.
- Immunization Exemptions: Letter Required. Attach to form.
  Religious ❑ Medical ❑

SECTION G: MENINGOCOCCAL WAIVER

DO NOT complete this section if you have received the vaccine or will not reside in campus housing.

I understand that Maryland law requires enrolled students in a Maryland institution of higher education and who reside in on-campus student housing be vaccinated against meningococcal disease. I may seek exemption from this law. I have read the meningitis bulletin available from the University of Maryland Health Center and at http://www.health.umd.edu/newandtransfer/immunizations/meningitis where the risks are detailed. In addition, I acknowledge the detrimental health effects of the disease. Lastly, I have read and understand the effectiveness of the vaccine, which is available from the University Health Center.

❑ I do not wish to receive the vaccine and I voluntarily agree to release, discharge, indemnify and hold harmless the State of Maryland, the University, its officers, employees and agents from any and all costs, liabilities, expenses, claims, demands, or causes of action on account of any loss or personal injury that might result from my non-compliance with the law.

To be completed by student and parent/guardian, if applicable.
I have read and signed this document with full knowledge of its significance. I further state that I am at least 18 years of age and competent to sign this waiver.

Student Signature_____ Date_____ UID#_____

Students under age 18: A parent/guardian must also sign this waiver.

Signature of Parent/Guardian_____ Date _____

Name of Parent/Guardian (Printed)_____

HLTH-601 (Revised 3.12)

MAKE A COPY OF THESE DOCUMENTS FOR YOUR PERSONAL FILES.

Revised 1.14

DO NOT SUBMIT THIS PAGE

NOTICES

- This Immunization Record form DOES NOT meet the Mandatory Health Insurance Requirement.
- All undergraduate students must have health insurance. For more information, go to www.health.umd.edu.
- Students must bring their health insurance card when being seen at the University Health Center.

REGISTRATION/IMMUNIZATION BLOCKS

The University of Maryland requires ALL students including: credit/non-credit, degree/non-degree seeking, full/part/half-time, undergraduate, graduate, transfer, International, or other student status to complete this Immunization Record form.

- Incomplete forms will NOT be processed and we will try to notify you by email.
- Students are permitted to register at the University of Maryland, College Park prior to submitting this form for the first class registration only.
- Failure to submit a completed Immunization Record will result in a Registration Block for the future semester and a non-compliance fee will be assessed. The Registration Block will be removed after the Immunization Record has been submitted and processed.
- To confirm immunization block removal: Wait one week after form has been submitted, then check: www.testudo.umd.edu
  (Click on *Office of the Registrar*, Click *Appointment and Registration Status* (under limited access), then Log In, Select *Academics and Testudo*, View *Registration and Time Blocks* box on left.)

Did you know?

- The Health Center **Pharmacy** participates with many pharmacy insurance plans, offers over-the-counter medications at discount prices, in addition to an array of Burt's Bees skin care products.
- Our **International Travel Clinic** offers immunization and guidance for international travel and studying abroad. Before you depart, make your first stop at the Health Center.
- The Health Center is in-network with the PPO and EPO insurance products of **Aetna**, **United Healthcare**, **Carefirst/Blue Cross Blue Shield**, and **Cigna**.
- Our **Women's Health Clinic** offers compassionate care for women including annual exams, colposcopy, contraceptive services and other testing.
- All **vaccines** are available at the Health Center at the most affordable prices.

For more information about all the services at the Health Center:

www.health.umd.edu

UNIVERSITY HEALTH CENTER

Leading the Way to Healthier Terps

DO NOT SUBMIT THIS PAGE.

DO NOT SUBMIT FORM MORE THAN ONCE, UNLESS REQUESTED BY THE UNIVERSITY HEALTH CENTER.

It may take several weeks to process the Immunization Record Form.

Check www.testudo.umd.edu for Immunization Status updates.