

Northwestern University Feinberg School of Medicine
APPLICATION FOR THE VISITING STUDENT ELECTIVE PROGRAM
2009-2010 Academic Year

Immunization form instructions:

1. All visiting students must have a Northwestern University immunization form filled out by a healthcare provider. There are 4 pages total.
2. No other form may be substituted.
3. Follow all instructions and attach lab reports as requested. All applicants must attach a Hepatitis B laboratory report in English. Failure to do so will result in an incomplete application.
4. Do not leave any lines blank. If attaching lab reports, indicate you are doing so by circling the sentence “Must attach a copy of lab report in English.”
5. Your healthcare provider must sign the form where requested. A Dean or Registrar’s signature will not be accepted on the Immunization Form.
6. You must complete page 1 and sign page 3.
7. All health documentation (lab reports, etc) must be in ENGLISH.
8. If you are an international student, and have proof of a PPD done in the United States, complete page 4.
9. If you are an international student and **DO NOT** have proof of a PPD done in the United States, leave page 4 blank. If accepted, you will receive a PPD test and/or chest x-ray at Northwestern.
10. Failure to follow instructions will result in an incomplete application.



NORTHWESTERN
UNIVERSITY

Mail this completed form to:

Northwestern University Feinberg School of Medicine

Visiting Student Programs
Augusta Webster Office of Medical Education
303 East Chicago Avenue, Ward 1-003
Chicago, IL 60611 USA

Visiting Medical Student Health Record

YOU MUST SUBMIT THIS FORM AND IMMUNIZATION/TB SKIN TEST VERIFICATION BEFORE YOU WILL BE PERMITTED TO START YOUR PROGRAM.

1. Complete Parts I-IV, in English.
2. Make sure to record your Name and Birthdate on top of all subsequent pages.
3. Have your healthcare provider complete and sign the **Immunization Verification** (Part II) and **PPD (TB skin test) Recording** (Part IV) sections, then return it to you. You should then review the form to make certain that your immunizations are up-to-date, that your healthcare provider has completed all sections properly, and that the form is signed and dated. Update any vaccinations as necessary. All submitted documentation MUST be in English.
4. Make a photocopy of all forms and mail the originals (Health Record, Immunization Verification, and PPD Recording Form) to the above address.

PART I – Student Demographics (Please print clearly or type)

Today's Date: ___/___/___

Last Name: _____ First Name: _____ Middle Initial: _____

Birthdate (mm/dd/yyyy): ___/___/___ Gender (check one): ___ Male ___ Female

Street Address (Home): _____ Apt#: _____ City: _____

State: _____ Country: _____ Zip/Postal Code: _____

Home Phone Number: (_____) _____ - _____

Country of origin (if not USA): _____ How long have you lived in the USA?: _____

E-MAIL ADDRESS: _____

IMPORTANT—PLEASE READ AND ANSWER!! The NU Health Service will confirm receipt of this form and whether or not you have met state and Northwestern immunization requirements. PLEASE SELECT BELOW THE (ONE) METHOD BY WHICH YOU WISH TO BE NOTIFIED:
 ___ **Email (preferred)** - Selection authorizes the Health Service to communicate entrance health requirement deficiencies via email.
 ___ **Standard mail** - Make sure you supply a valid mailing address above.

INDICATE YEAR ENTERING UNIVERSITY: 20___ What term? ___ Fall ___ Winter ___ Spring ___ Summer

Have you ever rotated at NU before? ___ Yes ___ No If so, when? _____

Have you ever attended Northwestern full-time? ___ No ___ Yes -- which campus? ___ Evanston ___ Chicago

List dates & programs attended full-time: _____

Name of Parent(s), Spouse, or Guardian: _____ Relationship(to student): _____

Address: _____ City/State: _____ Postal/Zip: _____

Country: _____ Phone: (_____) _____ - _____ Alternate Phone: (_____) _____ - _____

Email Address: _____

Is this person(s) your emergency contact? ___ Yes ___ No If "No", please provide emergency contact information below:

Name of Emergency Contact: _____ Relationship(to student): _____

Address: _____ City/State: _____ Postal/Zip: _____

Country: _____ Phone: (_____) _____ - _____ Alternate Phone: (_____) _____ - _____

Last Name (student): _____ First Name: _____ Birthdate: _____

PART II – IMMUNIZATION VERIFICATION

This section (including any attached reports) must be completed by your healthcare provider and signed at the end of the section for the information to be valid under Illinois law. A health care provider is a physician licensed to practice medicine (M.D. or D.O.), a Licensed Nurse, or a Public Health Official. Since you will attend school in Illinois, you are required to meet Illinois requirements, which may differ from your state or country. **IF A HEALTH CARE PROVIDER DOES NOT SIGN AND DATE AT BOTTOM, ANY DATES LISTED WILL NOT BE VALID.**

THE FOLLOWING ITEMS ARE REQUIRED FOR ALL FULL-TIME STUDENTS (Dates must be MM/DD/YYYY format):

MEASLES (Rubeola): ONE of the following options is required.		
1.	2 doses of live attenuated virus (MMR accepted) given on or after the 1st birthday, at least 28 days apart, and after 1-1-68. MUST LIST AT LEAST 2 DATES. Were either of these doses MMR vaccines? If so, which dose(s) (1 or 2)? _____	Date of dose #1: ____/____/____
OR 2.	Confirmation by physician's records of disease history and date of conclusive diagnosis.	Dose #2: ____/____/____ Date of illness: ____/____/____
OR 3.	Positive measles serology ----- Must attach a copy of laboratory report in English.	

MUMPS: ONE of the following options is required.		
1.	1 dose of live attenuated virus (MMR accepted) given on or after the 1st birthday and after 1-1-68.	Date of dose: ____/____/____
OR 2.	Confirmation by physician's records of disease history and date of conclusive diagnosis.	Date of illness: ____/____/____
OR 3.	Positive mumps serology ----- Must attach a copy of laboratory report in English.	

RUBELLA (German Measles): ONE of the following options is required.		
1.	Receipt of 1 dose of live rubella vaccine (MMR accepted) on or after the 1st birthday and after 1-1-69. Illness is NOT accepted for Rubella as immunity.	Date of dose: ____/____/____
OR 2.	Positive rubella serology ----- Must attach a copy of laboratory report in English.	

TETANUS/DIPHTHERIA: Include as many Dates (Primary Series and Booster Dose) as available		
Primary series of 3 or more doses of either DPT, DT, or Td vaccine at intervals not less than 0, 1, & 7 months. At least three dates preferred. (Please note —Tetanus toxoid (without Diphtheria toxoid) is not acceptable per State of Illinois law!)	Date of dose #1: ____/____/____ Dose #2: ____/____/____ Dose #3: ____/____/____	
Last Dose of Series or Booster Dose -----must be within 10 years of Registration at Northwestern (required of ALL students)	Date of last dose: ____/____/____	

HEPATITIS B: Serology results required.		
Positive serology for Hepatitis B surface antibody (10 IU/L or greater) done at least 4 weeks after third (or fourth) dose of vaccine. ----- Must attach a copy of laboratory report in English. Include Dates of Vaccine if available, but dates ALONE will NOT satisfy this requirement.	Date of dose #1: ____/____/____ Dose #2: ____/____/____ Dose #3: ____/____/____	

VARICELLA (CHICKEN POX): One of the following options is required.		
1.	2 doses of live attenuated virus given at least 28 days apart	Date of dose #1: ____/____/____ Dose #2: ____/____/____
OR 2.	Confirmation by physician's records of disease history and date of conclusive diagnosis.	Date of illness: ____/____/____
OR 3.	Positive varicella serology ----- Must attach a copy of laboratory report in English.	

RECOMMENDED for all students: MENINGOCOCCAL (THIS IS NOT A REQUIREMENT!!)		
1 dose of meningococcal vaccine within 3 years of registration.	Date of dose: ____/____/____	

****PPD (TB skin test) information recorded on page 4 (Part IV) of this form.***

Health care provider information and signature (Required)

Name of health care provider (PRINTED) Title (Physician, Nurse, etc.)

Signature of health care provider Date

Address Stamp

Street Address City/State Zip Phone number (____)____-____

Last Name (student): _____ First Name: _____ Birthdate: _____

Exemptions from Vaccine requirements may be made for the following circumstances:

- **Medical Contraindications:** a written, signed and dated statement from a healthcare provider stating the vaccine(s) that is(are) contraindicated, the medical condition or circumstances that contraindicates such immunization(s), and duration of the medical condition that prevents administering the vaccine(s). This statement will not be accepted if it does not meet the standards of care at Northwestern University.
- **Religious Exemption:** a written, signed, and dated statement from the church, student or the student's parent or guardian, if the student is a minor, documenting their objection based upon religious tenets or practice of a recognized church or religious organization, of which the student is an adherent or member. Please request and complete the "Religious Waiver and Release" form.
- **Pregnancy or Suspected Pregnancy:** a signed statement from a physician stating that the student is pregnant or is suspected of being pregnant. Pregnancy exemptions are only applicable to Measles, Mumps, Rubella, and Varicella requirements.
- **Age Exemption:** persons born before January 1, 1957 are considered immune from Measles, Mumps and Rubella.

Anyone with a Vaccination Exemption may be excluded from the University campus(es) in the event of a Measles, Mumps, Rubella, Diphtheria, or Varicella outbreak in accordance with Public Health Regulations.

PART III – PERMISSION FOR TREATMENT BY NORTHWESTERN UNIVERSITY HEALTH SERVICE

All students are advised to always carry their NU identification cards and the name, address, and policy number of their medical insurance. Northwestern University reserves the right to have any student admitted to the University examined by a Health Service physician. Please sign and date the following.

PERMISSION FOR TREATMENT OF PERSONS AGE 18 YEARS AND OVER

If you are 18 years of age or older and have completed the medical history sections, Parts II & III, then you must sign this section of the form.

No treatment will be provided if a signed permission for treatment form is not on file at the Health Service.

I certify that the foregoing information is true and complete to the best of my knowledge. I realize that the information that I have given in the medical history section is confidential and for the use of the Health Service staff. I give permission to Northwestern University to furnish such diagnostic, therapeutic, voluntary immunization, and operative procedures and transportation as may be deemed necessary on my behalf. I am 18 years of age or older. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of treatment or examination by the Health Service staff.

Student's Signature

Date

DO NOT WRITE BELOW THIS LINE—FOR HEALTH SERVICE USE ONLY!

NUHS Staff -- Record review of compliance with entrance requirements in this section

Date processed (mm/dd/yyyy): ____/____/____ By (initials): _____ COMPLIANT w/requirements? ____ YES ____ NO

If "NO", Please indicate deficiency below:

___ Health History	___ Rubella	___ PPD	___ Varicella
___ Permission	___ DT Booster	___ PPD Visit (5-9mm result)	___ Hep B Vaccine-- # ____
___ Measles #1 #2	DT series: #1 #2	___ Chest X-Ray	___ Hep B Titer
___ Mumps	___ TB Screening	___ +PPD, Physician Visit	___ Provider Signature

Notes: _____

Date student notified of compliance status: ____/____/____ By (initials): _____

Method of notification: ____ Email ____ Postcard

Date of compliance: ____/____/____ Record updated by (initials): _____

Student complete until: ____/____/____

Date Form Received (stamp)

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Part IV - PPD (TB skin test) Recording

All students in a healthcare-related program (e.g. Medical, Prosthetics-Orthotics, PT) must show proof or have a PPD. PPD's (TB skin test) **must be done in the USA** within **6 months prior to registration** at Northwestern and **MUST** be read by a health care provider within **48-72** hours of administration to be valid.

Tests done outside the USA will not be accepted.

Last Name (student): _____ First Name: _____

Date of Birth (MM/DD/YYYY): _____

Health Care Provider's Section:

This section MUST be completed and signed by a licensed health care provider. Please provide the information below:

Date test administered (MM/DD/YYYY): _____

Date test read (MM/DD/YYYY): _____

Reading/Result in millimeters induration: _____

If reading is 5 – 9mm, please ask student the following questions (Circle "Yes" or "No"):

- | | | |
|--|-----|----|
| 1) History of an abnormal chest x-ray? | Yes | No |
| 2) History of TB exposure? | Yes | No |
| 3) History of Immune Suppression? | Yes | No |

If reading is 10mm or greater, student must provide a report of a chest x-ray done in the USA within 6 months prior to registration at Northwestern, and are required to meet with a University Health Service physician.

Name of health care provider (printed): _____

Signature of provider

Date

Provider's phone number: (_____) _____

Address of provider/clinic (or address stamp):