Welcome to the Milwaukee Institute of Art & Design. MIAD contracts with Marquette University for its health services and the MU Student Health Service (SHS) provides students with a broad range of primary care, health promotion and disease prevention services. The SHS website provides helpful details: www.marquette.edu/shs

Enclosed you will find an Immunization Record, the Tuberculosis Screening and Medical History Forms. Marquette University’s SHS requires all MIAD students to submit the following information before they can receive medical treatment at the SHS:

- **2 MMR (measles, mumps, rubella) Vaccines OR 2 Measles, 1 Mumps, 1 Rubella Vaccine;**
  - Dose 1 on or after the first birthday; Dose 2 must be at least one month after the first dose. If immunization date is not available, a laboratory report of a blood test (titer) showing immunity will be accepted.
  - Vaccine/Titer not required for those born prior to 1957.

- **Tuberculosis Screening Questionnaire and results of Tuberculosis Testing/PPD if indicated**

In order to avoid delays, complete these forms or see your healthcare provider as soon as possible, especially if your immunizations are incomplete, and to get any required immunizations. Required immunizations are available from your healthcare provider, local health departments or the Marquette Student Health Service. You may contact SHS to arrange an appointment for any necessary immunizations and tests.

The information you submit will be maintained by the Student Health Service and will not be released to anyone without your knowledge and consent.

Please return the completed forms to the address noted in the box below at your earliest convenience. Failure to return your completed forms before classes begin will prevent you from receiving treatment at MU’s SHS.

<table>
<thead>
<tr>
<th>Health History Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>c/o Tony Nowak, Dean of Students</td>
</tr>
<tr>
<td>Milwaukee Institute of Art &amp; Design</td>
</tr>
<tr>
<td>273 E. Erie Street</td>
</tr>
<tr>
<td>Milwaukee, WI 53202</td>
</tr>
</tbody>
</table>

Questions about this form or the services provided by the SHS may be directed to: immunizations@marquette.edu or by calling the SHS at 414-288-7184.

PLEASE COMPLETE ALL PARTS OF THIS FORM AND MAKE A COPY OF THESE FORMS BEFORE SUBMITTING.
Effective in the Fall of 2006, all newly admitted or readmitted students are required to return this completed form to Student Health Services at the address above within 30 days of the start of the session/term of enrollment. **Failure to show proof of immunizations will result in a block in your registration for subsequent sessions/terms.**

**REQUIRED IMMUNIZATION**

Please complete this form as soon as possible. You may obtain dates/documentation from your health care provider or previous school records. If documentation/data is unavailable, a laboratory report of a blood test (titer) to determine level of immunity or re-immunization is required. Immunizations are available at the Marquette University Student Health Service for a fee. Call (414) 288-7184 for an appointment.

1. **MMR (measles, mumps, rubella)**
   Immunization with two doses of MMR, given on or after first birthday and separated by at least one month

   MMR #1 ___/___/___  MMR #2 ___/___/___
   (mos) (day)   (year)  (mos) (day)   (year)

   **OR**

   Measles #1 ___/___/___  Measles #2 ___/___/___  or attached lab report showing positive immunity
   (mos) (day)   (year)  (mos) (day)   (year)

   Mumps ___/___/___   (Date of last dose)  or attached lab report showing positive immunity
   (mos) (day)   (year)

   Rubella ___/___/___  (Date of last dose)  or attached lab report showing positive immunity
   (mos) (day)   (year)

**RECOMMENDED IMMUNIZATIONS**

<table>
<thead>
<tr>
<th>Meningitis Vaccine</th>
<th>Hepatitis B</th>
<th>Polio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose: <em><strong>/</strong></em>/___</td>
<td>Series of 3 doses; 0, 1, 6 months</td>
<td>Three doses</td>
</tr>
<tr>
<td>Date #1: <em><strong>/</strong></em></td>
<td>Date #1: <em><strong>/</strong></em></td>
<td></td>
</tr>
<tr>
<td>Date #2: <em><strong>/</strong></em></td>
<td>Date #2: <em><strong>/</strong></em></td>
<td></td>
</tr>
<tr>
<td>Date #3: <em><strong>/</strong></em></td>
<td>Date #3: <em><strong>/</strong></em></td>
<td></td>
</tr>
</tbody>
</table>

I HAVE READ AND UNDERSTAND THE IMMUNIZATION REQUIREMENTS OF THIS FORM AND THE ENCLOSED INFORMATION. This form has been truthfully completed to the best of my knowledge and I freely consent to this form being used for my treatment at Marquette University.

Student Signature: ____________________________________________  Date: __________

Parent Signature (if under 18 years of age): __________________________  Date: __________
**TUBERCULOSIS QUESTIONNAIRE**

All newly admitted students are required to submit this completed form to the Student Health Service within 30 days of the start of the session/term of enrollment.

NAME: ____________________________  DATE: ____________________________

To answer the following questions, please refer to the list below which details the list of countries with high rates of TB.*

<table>
<thead>
<tr>
<th>Afghanistan</th>
<th>Chad</th>
<th>Guinea</th>
<th>Macao SAR</th>
<th>Nigeria</th>
<th>Sri Lanka</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
<td>China</td>
<td>Guinea-Biss</td>
<td>Macedonia</td>
<td>Niue</td>
<td>Sudan</td>
</tr>
<tr>
<td>Armenia</td>
<td>Columbia</td>
<td>Guyana</td>
<td>Madagascar</td>
<td>N. Mariana Is.</td>
<td>Suriname</td>
</tr>
<tr>
<td>Azerbaijan</td>
<td>Comoros</td>
<td>Haiti</td>
<td>Malawi</td>
<td>Pakistan</td>
<td>Swaziland</td>
</tr>
<tr>
<td>Bahamas</td>
<td>Congo</td>
<td>Herzegovina</td>
<td>Malaysia</td>
<td>Palau</td>
<td>Syrian A.R.</td>
</tr>
<tr>
<td>Bahrain</td>
<td>Congo, DR</td>
<td>Honduras</td>
<td>Maldives</td>
<td>Panama</td>
<td>Tajikistan</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>Cote D'Ivorie</td>
<td>Hong Kong SAR</td>
<td>Mali</td>
<td>Papua N.G.</td>
<td>Tanzania URF</td>
</tr>
<tr>
<td>Belarus</td>
<td>Caucasus</td>
<td>India</td>
<td>Marshall Is.</td>
<td>Paraguay</td>
<td>Thailand</td>
</tr>
<tr>
<td>Benin</td>
<td>Djibouti</td>
<td>Indonesia</td>
<td>Mauritania</td>
<td>Peru</td>
<td>Togo</td>
</tr>
<tr>
<td>Bhutan</td>
<td>Democratic Republic</td>
<td>Iran</td>
<td>Mauritius</td>
<td>Philippines</td>
<td>Tokelau</td>
</tr>
<tr>
<td>Bolivia</td>
<td>Ecuador</td>
<td>Kazakhstan</td>
<td>Micronesia</td>
<td>Portugal</td>
<td>Turkmenistan</td>
</tr>
<tr>
<td>Bosnia</td>
<td>El Salvador</td>
<td>Kenya</td>
<td>Moldova Rep.</td>
<td>Principe</td>
<td>Uganda</td>
</tr>
<tr>
<td>Botswana</td>
<td>Equ. Guinea</td>
<td>Kiribati</td>
<td>Mongolia</td>
<td>Romania</td>
<td>Ukraine</td>
</tr>
<tr>
<td>Brazil</td>
<td>Eritrea</td>
<td>Korea, DPR</td>
<td>Morocco</td>
<td>Russian Fed.</td>
<td>Uzbekistan</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>Ethiopia</td>
<td>Kyrgyzstan</td>
<td>Myanmar</td>
<td>Sao Tome</td>
<td>Vietnam</td>
</tr>
<tr>
<td>Burundi</td>
<td>Gabon</td>
<td>Lao PDR</td>
<td>Namibia</td>
<td>Senegal</td>
<td>Yemen</td>
</tr>
<tr>
<td>Cambodia</td>
<td>Georgia</td>
<td>Latvia</td>
<td>Nepal</td>
<td>Sierra Leone</td>
<td>Zambia</td>
</tr>
<tr>
<td>Cameroon</td>
<td>Ghana</td>
<td>Lesotho</td>
<td>N. Caledonia</td>
<td>Solomon Is.</td>
<td>Zimbabwe</td>
</tr>
<tr>
<td>Cape Verde</td>
<td>Guam</td>
<td>Liberia</td>
<td>Nicaragua</td>
<td>Somalia</td>
<td></td>
</tr>
</tbody>
</table>


1. To the best of your knowledge, have you had close contact with anyone who was sick with tuberculosis (TB)?
   - YES   - NO

2. Were you born in one of the countries on the above list?
   - YES   - NO

3. Have you lived or traveled for more than one month in any of the countries on the above list?
   - YES   - NO

If you have answered YES to any of the above questions, a PPD (Mantoux) skin test is required, even if you have had BCG vaccination in the past. Test must have been performed within one year before enrollment and must be completed in the United States.

This test will be available, if necessary, at the Marquette Student Health Service after you arrive on campus. Please contact SHS by telephone (414-288-7184) for an appointment.

Health Care Provider must complete and sign below as proof of test:

<table>
<thead>
<tr>
<th>Date Administered:</th>
<th>Date Test Read:</th>
<th>Skin Test Result (size of induration)</th>
<th>Chest X-Ray</th>
<th>Health Care Provider</th>
<th>Treatment (if any)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>mm</td>
<td>Required if TB skin test is positive</td>
<td>Signature</td>
<td></td>
</tr>
<tr>
<td>Date of X-ray</td>
<td>Result: NEG POS</td>
<td>(attach copy of written report)</td>
<td></td>
<td>Address:</td>
<td></td>
</tr>
</tbody>
</table>

*Health Care Provider signature and address.*
Medical History

Please answer all questions. Consult your health care provider and parents for accurate, complete answers. The information is treated confidentially and will not affect your admission status.

Name: _______________________________ MU ID#: __________________ Date: ______________

LAST     FIRST      MIDDLE

List any chronic or recurrent medical conditions or any condition that you regularly take medication for:

________________________________________________________

________________________________________________________

________________________________________________________

□ None

List any medical problems in any of your immediate family members (parents, siblings, grandparents) for example, high blood pressure, diabetes, cancer, etc.

________________________________________________________

________________________________________________________

________________________________________________________

□ None

List any past surgeries, serious illness, injuries or hospitalizations:

________________________________________________________

________________________________________________________

________________________________________________________

□ None

List current medications (including oral contraceptives):

________________________________________________________

________________________________________________________

________________________________________________________

□ None

Are you currently under a physician’s care? □ Yes  □ No  If yes, explain:

________________________________________________________

________________________________________________________

________________________________________________________

List medication allergies or adverse drug reactions (include type of reaction):

________________________________________________________

________________________________________________________

________________________________________________________

□ None

Name and address of current physician(s):

________________________________________________________

________________________________________________________

________________________________________________________

Insurance Data

Are you in an HMO or PPO?  □ Yes  □ No

Name of insurance company: ___________________________________________________________

Group No.: ___________________________

Cert. No.: ___________________________

Insurance phone number to call in emergency: ___________________________

Please obtain a copy of your medical insurance card to keep it with you.

Emergency Contact

Name: _______________________________ Relationship to student: __________________________

Home telephone: (___) __________________________ Work telephone: (___) __________________________

Parental consent for care of students under age 18

The law requires that a parent/guardian grant permission for medical evaluation and/or treatment of minors (anyone under 18 years of age). The following consent must be signed by a parent/guardian of a minor so that he/she may receive medical evaluation/treatment. No major medical or surgical procedure will be performed, except in an emergency, without the parent/guardian first being contacted.

Authorization: I concur with the above and authorize, at the discretion of Student Health Service personnel, medical and surgical care including examinations, treatments, immunizations and the like for my son or daughter. In the event of serious disease or injury or the need for major surgery, I understand that all reasonable efforts will be made to contact me, but that failure to make contact will not prevent emergency treatment necessary to help preserve life or health.

Name of parent/guardian: _______________________________ Work telephone: (___) __________________________

Signature of parent/guardian: ___________________________ Date: __________________________