Baker College Health Information Form
Part 1 of 2

Students must complete the first part of this form before taking it to their healthcare provider (physician, nurse practitioner, physician assistant or public health official) to have the remainder of the form completed.

When completed, return to: Program Director or Director of Nursing

Student Name: _____ UIN: _____ DOB: _____

Address: _____

City: _____ ST: _____ Zip: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Program at Baker College: _____

Emergency Contact Information: Person to notify in case of an emergency

Contact Name: _____

Relationship : _____

Address: _____

City: _____ ST: _____ Zip: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Physician Information

Primary Physician: _____

Address: _____

City: _____ ST: _____ Zip: _____

Phone: _____ Fax: _____

Health Insurance Coverage

Company Name: _____

Policy / Group No: _____

I hereby give my consent for Baker College to share the information contained here with appropriate college personnel, emergency personnel, and clinical or externship affiliation sites, should the need arise.

Student Signature: _____ Date: _____

Baker College Health Information Form Part 2 of 2

Student Name: _____ UIN: _____ DOB: _____

Please provide proof of immunizations. If you are currently receiving a specific immunization or unable to provide proof of immunization, titers will need to drawn. Immunization for the following is a requirement for the Health Science programs.

Immunization Record:

Document immunizations done previously or done at this time.

Immunization	**Date of Immunization**	**Date of Disease**		**Hepatitis B Vaccine**	**Date**
MMR				1st Dose	
Varicella Zoster (Chicken Pox)				2nd Dose	
Immunization	**Date of Immunization**	**Date of Disease**		3rd Dose	
Polio				Booster	
Tdap				**Influenza Immunization**	**Date**
COVID Vaccine	**Date of Immunization & Manufacturer**	**Date of Disease**		Influenza	
Primary Dose					
Secondary Dose					
1st. Booster					
2nd. Booster					

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Baker College Health Information Form Part 2 of 2 Cont.

Documentation of Titers:

Document titers done previously or done at this time.

Titer	Date of Titer	Immune	Non-Immune: Date(s) of subsequent vaccination	Non-Immune: Date(s) of subsequent vaccination(s)
Rubella Titer				
Rubeola Titer				
Mumps Titer				
Varicella Zoster Titer (Chicken Pox)				
Hepatitis B Titer				
Hepatitis B Surface Antibody				
Hepatitis B Surface Antibody Quantative				
Hepatitis B Surface Antigen				
Hepatitis C Antibody (*If Required*)				
COVID Titer				
COVID Titer				
COVID Titer				

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Baker College Health Information Form Part 2 of 2 Cont.

Student Name: _____ UIN: _____ DOB: _____

***If you have been getting Tb testing done every year and it has been less than a year since your last Tb test, you do not have a Tb test done. We just need a copy of your current Tb tests, within the last 12 months.**

Tuberculosis Testing (1 step) *Attach the last two Tb tests if you have not let your Tb tests expire*	**Date of Test**	**Result**
Testing Information (Must be done within last 12 months)		
Chest X-Ray (if previously positive or unable to do Tb test)		
QuantiFERON TB Gold Test (QFT-G) (see above)		

Tuberculosis Testing (2 step)
If you have let your Tb test expire or you have never had a Tb test before, you must do the 2 step Tb test. Once you have had the 2 step Tb test, subsequent Tb testing will be the 1 step

	Date of Test	**Result**	**Date of 2nd Test**	**Result**
Testing Information (Must be done within last 12 months)				
Chest X-Ray				
QuantiFERON TB Gold Test (QFT-G)				

Note: You must attach a copy of results for both the 1st test and the 2nd test.

I certify that this individual's immunization status has been reviewed and deemed to be complete and up to date.

Physician/NP/PA/RN Signature: _____ Date: _____

For Baker College Of ice Use Only:

Reviewed By (Print Name and Title): _____

Reviewer Signature: _____

Notes: