May 2015

Dear Students and Parents:

As the Director at Claremont University Consortium Student Health Services, I am writing to inform you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis, and the current recommendation from the Centers for Disease Control and Prevention (CDC) along with the recommendations of the Advisory Committee on Immunization Practices (ACIP).

In 1997, the CDC's Advisory Committee on Immunization Practices (ACIP) voted to recommend that college students, particularly freshmen living in dormitories and residence halls, be educated about meningitis and the benefits of vaccination. The panel based its recommendation on recent studies showing that college students, particularly freshmen living in dormitories, have a six-fold increased risk for meningitis. The recommendation further states that information about the disease and vaccination is appropriate for other undergraduate students who also wish to reduce their risk for the disease. This information again published in June 2000 and was included in the CDC's 2015 information and recommendations.

Meningitis is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. If not treated early, meningitis can lead to swelling of the fluid surrounding the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation, and even death.

Cases of meningitis among teens and young adults 15 to 24 years of age (the age of most college students) have more than doubled since 1991. The disease strikes about 3,000 Americans each year and claims about 300 lives. Between 100 and 125 meningitis cases occur on college campuses nationwide and as many as 15 students will die from the disease.

The Claremont Colleges, in an effort to keep the campus safe and as healthy as possible, now require all incoming freshmen to show proof of meningococcal vaccination. The vaccine is available at the Student Health Services any day by appointment. For more information, please feel free to contact our health service and/or consult the student’s health care provider. You can also find information about this disease on our web site, www.cuc.claremont.edu/shs/, which links to the web site for the Centers for Disease Control and Prevention (CDC), http://www.cdc.gov/, and the American College Health Association web site, www.acha.org/Topics/meningitis.cfm.

Sincerely,

Jennie Ho, M.D.
Director, Student Health Service
AFFIDAVIT FOR EXEMPTION TO MEDICAL REQUIREMENTS

The Claremont Colleges requires its students to have a complete physical examination and series of immunizations. Immunization requirements include completion of the diphtheria, pertussis, tetanus primary series (DPT, Td or Tdap), a Td booster within the last 10 years, two doses of measles, mumps, and rubella (MMR), and a meningococcal vaccine. Recommended, but not required is the Hepatitis B vaccine series. Those students who request a religious/personal exemption must complete the following form:

1. Signature, as an affidavit for exemption to immunizations (signed below) by the applicant or, if a minor, by his/her parent of legal guardian. This affidavit verifies the student’s request for exemption from the immunizations required by The Claremont Colleges because it conflicts with the tenets and practices of a recognized church, religious denomination or recognized religious organization of which the applicant is an adherent or member or due to personal beliefs.

2. Prior to admission, for the protection of those on campus, we do require that all students, even those claiming exemption to other immunizations, must provide proof of freedom from tuberculosis by completing the TB screening questionnaire.

I have read and understand all of the above exemptions/requirements and agree to provide all necessary documentation prior to admission.

Name of Student _______________________________________________________________ (Print)

Date of Birth ___________________________ School ____________________________

Signature of Student _____________________________________________________________
(Parent or Guardian if student is a minor)

Date _________________________________________________________________________
In order to provide a safe and healthy environment at The Claremont Colleges, **all** students are required to complete this health record **prior** to entry.

**IMPORTANT GENERAL INFORMATION**
- Please read prior to completing this form:
  - Director’s letter of introduction
  - Information on meningococcal disease (Revised 2015)
- If documentation of immunization is unavailable, you must be re-immunized for measles, mumps, and rubella or show proof of immunity. Meningococcal vaccination is required.
- All forms may be submitted by mail to the above address or e-mail to shsrecords@cuc.claremont.edu.
- **Please make a copy of this form for your records.**

*This form must be returned by August 1<sup>st</sup> for the fall semester and January 15<sup>th</sup> for the spring semester.*

---

**Part I: TO BE COMPLETED BY STUDENT**

| Full Legal Name |   |   |   | Date of Birth: |
|-----------------|--|--|--|--:|---|---|---|
| Last            | First | Middle |
| Sex: Male       | Female | Not listed (Please Specify) |
| Date of Birth:  | Month | Day | Year |

<table>
<thead>
<tr>
<th>ID#</th>
<th>Home Address</th>
<th>Street</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary Phone</th>
<th>E-mail Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>(____)</td>
<td></td>
</tr>
</tbody>
</table>

**Emergency Contact:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Phone Number (Primary)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(____)</td>
</tr>
</tbody>
</table>

Address: Phone Number (Work) (____)

---

**MEDICAL CARE AUTHORIZATION**

I, the undersigned, hereby specifically authorize the Claremont University Consortium Student Health Services health care provider or whomever he or she may designate to administer any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, in serious or major illnesses or injuries without prior notification of the undersigned or any other person and without obtaining consent of the undersigned or any other person, if in the judgment of the physician or designee it is necessary for health care reasons to proceed with the treatment without delay. I further agree that the attending health care provider or whomever he or she may designate may evaluate and treat all other injuries or illnesses for which help is sought. In the case of a minor student, (under the age of 18), this treatment may proceed without prior notification of the undersigned parent or guardian. I further agree that the Student Health Services may release any medical information to other campus health care providers at Monsour Counseling and Psychological Services who may be providing care.

**SIGNATURE OF STUDENT:** All students must sign. If under 18 years of age, Parental Signature is also required.

<table>
<thead>
<tr>
<th>STUDENT</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PARENT</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NOTE: A release of information must be signed and dated and on file for students 18 and older before any patient records and/or, billing information may be released/discussed with a student, parent, guardian, spouse, or healthcare provider. A form is available at www.cuc.claremont.edu/shs/docs/SHS_Release_of_Medical_Records_Permission.pdf or at Student Health Services.
PART II: PERSONAL HEALTH HISTORY: TO BE COMPLETED BY STUDENT

<table>
<thead>
<tr>
<th>YES</th>
<th>Acne, severe</th>
<th>YES</th>
<th>Genital warts (HPV)</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>Alcohol/Drug addiction</td>
<td>YES</td>
<td>Headaches, frequent, severe</td>
</tr>
<tr>
<td>YES</td>
<td>Allergies of any kind</td>
<td>YES</td>
<td>Head injury</td>
</tr>
<tr>
<td>YES</td>
<td>Anemia</td>
<td>YES</td>
<td>Hearing difficulty</td>
</tr>
<tr>
<td>YES</td>
<td>Anxiety or panic attacks</td>
<td>YES</td>
<td>Heart disease</td>
</tr>
<tr>
<td>YES</td>
<td>Arthritis</td>
<td>YES</td>
<td>Heart murm/Arrhythmia</td>
</tr>
<tr>
<td>YES</td>
<td>Asthma, including exercise induced</td>
<td>YES</td>
<td>Hepatitis</td>
</tr>
<tr>
<td>YES</td>
<td>Attention deficit disorder/ADHD</td>
<td>YES</td>
<td>High blood pressure</td>
</tr>
<tr>
<td>YES</td>
<td>Back pain, chronic</td>
<td>YES</td>
<td>Immune system problem</td>
</tr>
<tr>
<td>YES</td>
<td>Bipolar disorder</td>
<td>YES</td>
<td>Kidney disease</td>
</tr>
<tr>
<td>YES</td>
<td>Blood clotting disorder</td>
<td>YES</td>
<td>Leukemia</td>
</tr>
<tr>
<td>YES</td>
<td>Cancer</td>
<td>YES</td>
<td>Loss of a paired organ</td>
</tr>
<tr>
<td>YES</td>
<td>Chickenpox</td>
<td>YES</td>
<td>Meningitis/Encephalitis</td>
</tr>
<tr>
<td>YES</td>
<td>Crohn’s Disease/Ulcerative colitis</td>
<td>YES</td>
<td>Menstrual problems</td>
</tr>
<tr>
<td>YES</td>
<td>Depression</td>
<td>YES</td>
<td>Mononucleosis</td>
</tr>
<tr>
<td>YES</td>
<td>Diabetes</td>
<td>YES</td>
<td>Ovarian cyst</td>
</tr>
<tr>
<td>YES</td>
<td>Ear, nose, or throat disorders</td>
<td>YES</td>
<td>Pneumonia</td>
</tr>
<tr>
<td>YES</td>
<td>Eating disorder</td>
<td>YES</td>
<td>Positive tuberculin skin test</td>
</tr>
<tr>
<td>YES</td>
<td>Epilepsy/Seizures</td>
<td>YES</td>
<td>Psychiatric treatment</td>
</tr>
<tr>
<td>YES</td>
<td>Fainting/Blackouts</td>
<td>YES</td>
<td>Sickle cell trait/disease</td>
</tr>
</tbody>
</table>

If you answered “YES” to any of the conditions listed above, please explain in the space below. Give the date and outcome of all conditions above or any other conditions or medical history not listed. You may attach additional sheets and old medical records if necessary.

_________________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________________

List all other surgical procedures, except fractures, with dates ____________________________________________________________

List all medical/psychiatric hospitalizations, with dates ________________________________________________________________

List all significant injuries and illnesses, with dates ______________________________________________________________________

List any medications taken regularly _____________________________________________________________

List Allergy/Medication Reaction History ____________________________________________________________
PART III: MEDICAL INSURANCE

It is required that all students be covered by medical insurance to provide supplemental coverage for medical costs in the event of a severe illness, injury, or accident. Claremont College requires each student to submit proof of coverage prior to registration. The Claremont University Consortium Student Health Services does not do any medical insurance billing. However, information about a student’s medical coverage can expedite the process of community subspecialty referrals if necessary as well as an insurance identification card carried by the student. Please provide current medical insurance information below:

Name of Insurance Carrier ________________________________________________

Policy Number(s) __________________________ Phone Number for Reporting Claims ________________________________
TO THE HEALTH CARE PROVIDER: Please review the health history provided by the student and add or complete anything of significance. After a complete physical examination, we would appreciate your evaluation of the student’s physical status, both for the student and as a basis for his/her continuing medical care.

- **Height** __________
- **Weight** __________
- **Pulse** __________
- **Blood Pressure** __________

**Vision:** (Uncorrected) R 20/______  L 20/______ (Corrected) R 20/______  L 20/______

List any allergies to medications or foods ____________________________________________________________

### PHYSICAL EXAM

<table>
<thead>
<tr>
<th>NORMAL</th>
<th>ABNORMAL</th>
<th>EXPLANATION OF ABNORMAL FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head/EENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neck/Lymph/Thyroid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hernia/Testicles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculo-skeletal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurologic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### A. TUBERCULOSIS SCREENING (Required)

1. Does the student have a history of a positive tuberculin skin test (PPD) in the past?  
   - □ Yes  □ No
   
   If no, proceed to #2.
   
   If yes, include date of positive PPD, mm induration, date and results of most recent chest x-ray and documentation of any treatment received for latent tuberculosis. **Skin test should not be repeated.** Proceed to #2.

2. Does the student have signs or symptoms of active tuberculosis disease?  
   - □ Yes  □ No
   
   If no, proceed to #3.
   
   If yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.

3. Is the student a member of a high-risk group?  
   - □ Yes  □ No

**Categories of high-risk students include those students who were born in or resided in countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Therefore students should undergo TB screening if they were born in or resided in countries EXCEPT those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia, USA, Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand. Other categories of high-risk students include those with HIV infection, who inject drugs, who have resided in, or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone ≥ 1 month) or other immunosuppressive disorders.**

If no, stop. Proceed to Section B.

If yes, place tuberculin skin test [Mantoux only: Inject 0.1 ml of purified protein derivative (PPD) tuberculin containing 5 tuberculin units (TU) intradermally into the volar (inner) surface of the forearm]. A history of BCG vaccination should not preclude testing of a member of a high-risk group.

**Tuberculin Skin Test: (Must be performed within 6 months of arrival on campus)**

- **Date Placed:** _______________  **Date Read:** _______________  
  **Result:** _______________  (Record actual mm of induration, transverse diameter; if no induration, write “0”).

**Interpretation (Based on mm induration as well as risk factors.):**  
- □ Positive  □ Negative

4. Chest x-ray result (Required only if tuberculin skin test in #3 is positive): Date of CXR: ___________________
   - □ Normal  □ Abnormal

---

757 College Way, Claremont, CA 91711  
(909) 621-8222  (909) 621-8472 F
PART V: IMMUNIZATION RECORD: TO BE COMPLETED BY THE HEALTH CARE PROVIDER

B. IMMUNIZATIONS (Please fill out below) OR Attach a copy of the Immunization Record

Tetanus, Diphtheria, Pertussis (DPT, Dtap, DT, Td, Tdap) REQUIRED
#1_________ #2_________ #3_________ #4_________ Booster within last 10 years ____________

Measles, Mumps, Rubella (MMR) (REQUIRED)
MMR #1_________ MMR #2_________ Or had disease verified by a health care provider Y N
Immunity verified by immune titer (please include lab report)

Meningococcal Tetravalent (REQUIRED) Tetravalent conjugate (preferred) Date ____________
Tetravalent polysaccharide Booster ____________

Polio #1_________ #2_________ #3_________ #4_________ Last booster ____________

Hepatitis A #1______________ #2______________

Hepatitis B #1______________ #2______________ #3______________

Human Papillomavirus (2, 4, or 9 valent) #1_________ #2_________ #3_________

Pneumococcal Polysaccharide vaccine Date ____________

Typhoid (Circle: Intramuscular/Oral) Date ____________

Varicella #1_________ #2_________ Disease (date) ____________

Yellow Fever Date ____________

List all medications you are prescribing for the patient ____________________________________

____________________________________________________________________________________

Please describe any current treatment and recommended further treatment _______________________________________________________________________

____________________________________________________________________________________

Recommendations for intramural/intercollegiate physical activity

☐ May participate in sports without restrictions
☐ Should not participate in sports (please explain): __________________________________________

☐ May participate with the following restrictions: ____________________________________________

☐ Medical or orthopedic problem must be evaluated before participation is allowed (please explain): ____________________________________________

PART VI: HEALTH CARE PROVIDER SIGNATURE

Health Care Provider’s Name (please print) ____________________________

Address ____________________________ City ____________________________ State ____________ Zip code ____________

Phone (______) ____________________________ Fax (______) ____________________________

Area code ____________________________ Area code ____________________________

Signature ____________________________ Date ____________________________

757 College Way, Claremont, CA 91711
(909) 621-8222  (909) 621-8472 F
Please fill out this form carefully and completely. REQUIRED by the Health Insurance Portability and Accountability Act, (45 C.F.R. Parts 160 and 164).

Use Ink & Print Clearly

I, __________________________ authorize __________________________ to use or disclose my protected health information including any photographs that have been taken to assist in my care as indicated below to:

Name: Student Health Services

Daytime Phone#  909-607-2500

Fax#  909-621-8472

Address: Attention Medical Records
757 College Way

City: Claremont
State: CA
Zip Code: 91711

2. Information to be released: Identify dates and specific request

From & To Dates: ____________________________

☐ Lab report: ________________________________

☐ History and physical exam: __________________

☐ X-ray report: ______________________________

☐ At the request of the individual ______________

Other: ___________________________________________________________________

__________________________________________________________________________

3. Authorization: Please read carefully

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to:

☐ Substance Abuse (including alcohol/drug abuse)

☐ Mental Health

☐ Psychotherapy Notes

☐ HIV related information (including AIDS related testing)

☐ Other (please specify): ____________________________

The confidentiality of this record is required under California Health & Safety Code 120975 to 21020, as well as, title 42 of the United States code. The material shall not be transmitted to anyone without written consent or authorization as provided in these statutes.

X ____________________________ Date ____________________________

Signature of Patient or Legal Guardian
RELEASE OF MEDICAL RECORDS AND MEDICAL INFORMATION
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. I understand that this authorization will expire two years from my last date of service visit. A photocopy of this form will be considered as valid as the original.

2. I understand that I may revoke this authorization at any time by notifying the SHS Medical Records Manager at the address indicated above, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.

4. My health care and payment for my health care will not be affected if I do not sign this form.

5. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.

6. I understand that I may obtain a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this Authorization.

Signature of Patient __________________________ Date of Birth ________ Date __________

Parent/Legal Guardian/Authorized Person __________________________ Relationship to Patient

Record Received By __________________________ Date __________

For Office Use Only

Date Requested Filled __________________________ By __________________________

Identification Presented __________________________ Fee Collected __________________________
Please fill out this form carefully and completely. REQUIRED by the Health Insurance Portability and Accountability Act, (45 C.F.R. Parts 160 and 164).

Use Ink & Print Clearly

I, __________________________________________________, authorize Student Health Services to use or disclose my protected health information including any photographs that have been taken to assist in my care as indicated below to:

Name: ______________________________________________________________ 

(Complete Name: Parent, Spouse, Physician, Employer or Other)

Daytime Phone# ________________________________  Fax# ________________________________

Address ______________________________________________________________ 

City ____________________________ State ____________________________ Zip Code __________________

2. Information to be released: Identify dates and specific request

From & To Dates: ________________________________________________________ 

☐ Lab report: _________________________________________________________

☐ History and physical exam: ___________________________________________ 

☐ X-ray report: _______________________________________________________

☐ At the request of the individual _______________________________________

Other: _______________________________________________________________

____________________________________________________________

3. Authorization: Please read carefully

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to:

☐ Substance Abuse (including alcohol/drug abuse)

☐ Mental Health

☐ Psychotherapy Notes

☐ HIV related information (including AIDS related testing)

☐ Other (please specify): _____________________________________________

The confidentiality of this record is required under California Health & Safety Code 120975 to 21020, as well as, title 42 of the United States code. The material shall not be transmitted to anyone without written consent or authorization as provided in these statutes.

X ________________________________ ____________________________________

Signature of Patient or Legal Guardian Date
RELEASE OF MEDICAL RECORDS AND MEDICAL INFORMATION
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. I understand that this authorization will expire two years from my last date of service visit. A photocopy of this form will be considered as valid as the original.

2. I understand that I may revoke this authorization at any time by notifying the SHS Medical Records Manager at the address indicated above, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.

4. My health care and payment for my health care will not be affected if I do not sign this form.

5. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.

6. I understand that I may obtain a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this Authorization.

____________________________ __________________________
Signature of Patient
Date of Birth Date

____________________________ __________________________
Parent/Legal Guardian/Authorized Person Relationship to Patient

Record Received By Date

For Office Use Only

____________________________
Date Requested Filled

By _____________________________
Identification Presented Fee Collected

Student Health Services
757 College Way
Claremont, CA 91711
Phone: 909 621-8222
FAX: 909 621-8472