CLAREMONT UNIVERSITY CONSORTIUM STUDENT HEALTH SERVICES

☐ Claremont McKenna College
☐ Harvey Mudd College
☐ Pitzer College
☐ Pomona College
☐ Scripps College

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
- If documentation of immunization is unavailable, you must be re-immunized for Hepatitis B, Measles, Mumps, Rubella, and Varicella Zoster or show proof of immunity. Meningococcal vaccination is required.
- All forms may be submitted by e-mail to shsrecords@cuc.claremont.edu.
- **Please make a copy of this form for your records.**

This form must be returned by August 1st for the fall semester and January 15th for the spring semester.

Part I: TO BE COMPLETED BY STUDENT ***Use Ink & Print Clearly***

Full Legal Name _____
Last First Middle

Sex: ☐ Male ☐ Female ☐ Not listed (Please Specify) _____ Date of Birth: _____
Month Day Year

ID# _____ Home Address _____
Street

_____
City State Zip Code Country

Primary Phone ( ) _____ E-mail Address _____

Emergency Contact:

Name _____ Relationship _____ Phone Number (Primary) ( ) _____

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.

STUDENT _____ DATE _____

PARENT _____ DATE _____

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 http://www.cuc.claremont.edu/shs/docs/SHS_Release_of_Medical_Records_Permission-SHStoAnotherProvider.pdf or at Student Health Services.

CLAREMONT UNIVERSITY CONSORTIUM

STUDENT HEALTH SERVICES

Part II

Patient Name _____

PART II: PERSONAL HEALTH HISTORY: TO BE COMPLETED BY STUDENT

Have you ever been diagnosed with any of the following?

YES

- ❑ Acne, severe
- ❑ Alcohol/Drug addiction
- ❑ Allergies of any kind
- ❑ Anemia
- ❑ Anxiety or panic attacks
- ❑ Arthritis
- ❑ Asthma, including exercise induced
- ❑ Attention deficit disorder/ADHD
- ❑ Back pain, chronic
- ❑ Bipolar disorder
- ❑ Blood clotting disorder
- ❑ Cancer
- ❑ Chickenpox
- ❑ Crohn's Disease/Ulcerative colitis
- ❑ Depression
- ❑ Diabetes
- ❑ Ear, nose, or throat disorders
- ❑ Eating disorder
- ❑ Epilepsy/Seizures
- ❑ Fainting/Blackouts
- ❑ Genital herpes

YES

- ❑ Genital warts (HPV)
- ❑ Headaches, frequent, severe
- ❑ Head injury
- ❑ Hearing difficulty
- ❑ Heart disease
- ❑ Heart murmur/Arrhythmia
- ❑ Hepatitis
- ❑ High blood pressure
- ❑ Immune system problem
- ❑ Kidney disease
- ❑ Leukemia
- ❑ Loss of a paired organ (eye, kidney, testicle)
- ❑ Meningitis/Encephalitis
- ❑ Menstrual problems
- ❑ Mononucleosis
- ❑ Ovarian cyst
- ❑ Pneumonia
- ❑ Positive tuberculin skin test
- ❑ Psychiatric treatment
- ❑ Sickle cell trait/disease

YES

- ❑ Self Injury
- ❑ Thyroid condition
- ❑ Urinary tract infection (recurrent)
- ❑ Other _____

Do you have a family history of any of the following conditions? (parents, grandparents, or siblings)

- ❑ Blood clotting disorder
- ❑ Cancer
- ❑ Diabetes
- ❑ Heart disease
- ❑ High blood pressure
- ❑ Kidney disease
- ❑ Mental illness
- ❑ Migraine
- ❑ Rheumatoid arthritis
- ❑ Sudden death
- ❑ Thyroid disease
- ❑ Other _____

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 _____

_____

757 College Way, Claremont, CA 91711
(909) 621-8222 (909) 621-8472 F

Patient Name _____

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 _____

Patient Name _____

Part IV: PHYSICAL EXAMINATION: TO BE COMPLETED BY A HEALTH CARE PROVIDER ONLY
Form completed by family member/relative will not be accepted.

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	NORMAL	ABNORMAL	EXPLANATION OF ABNORMAL FINDINGS
Head/EENT			
Neck/Lymph/Thyroid			
Cardiovascular			
Respiratory			
Breast exam			
Abdomen			
Hernia/Testicles			
Musculo-skeletal			
Neurologic			
Skin			

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

Or Interferon Gamma Release Assay (IGRA): Date Obtained:_____(Specify Method) ☐QFT-G ☐QFT-GIT ☐Other _____
Result: ☐ Positive ☐ Negative ☐ Intermediate

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

Patient Name _____

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**

Hepatitis B #1_____#2_____#3_____ **(REQUIRED)**

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 _____

Varicella #1_____#2_____Disease (date) _____ **(REQUIRED)**

Recommended Immunizations

Polio #1_____ #2_____ #3_____ #4_____ Last booster_____

Hepatitis A #1_____

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

Pneumococcal Polysaccharide vaccine Date_____

Typhoid (Circle: Intramuscular/Oral) Date_____

Yellow Fever Date_____

Meningococcal B Bexsero #1_____#2_____**or** Trumenba #1_____#2_____#3_____

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 _____

Street City State Zip code Country

Phone (_____) _____ Fax (_____) _____

Area code Area code

Signature_____ Date _____