

# CALIFORNIA INSTITUTE OF TECHNOLOGY

STUDENT HEALTH CENTER MAIL CODE 1-8

PASADENA, CALIFORNIA 91125

(626) 395-6393, Fax (626) 585-1522

## INSTRUCTIONS AND INFORMATION:

1. The primary purpose of this form is to assure that immunizations are current and that the student poses no public health problems. It also provides a means of identifying students with special health needs and an historical basis for the provision of health care through the Student Health Service.
2. This form must be **returned to the Student Health Center by July 31. All pages must be completed.** (Return the completed form in the envelope provided). **Partially completed forms will not be processed.**
3. **Registration will be withheld until these forms are returned with documentation of required immunization and results of all laboratory tests as indicated.**
4. Information on this form is **CONFIDENTIAL** and to be used solely for the Health Services, and will not be released without the student's consent.

## PERSONAL HISTORY (To be filled out by applicant)

NAME \_\_\_\_\_

Last

First

Middle

HOME ADDRESS \_\_\_\_\_

Street

City, State/Country

Zip Code

HOME PHONE NUMBER (Include area code) \_\_\_\_\_

E-MAIL ADDRESS (if available) \_\_\_\_\_

SEX: Female \_\_\_\_\_ Male \_\_\_\_\_ Date of Birth \_\_\_\_\_

Undergraduate \_\_\_\_\_

Graduate \_\_\_\_\_

Month/day/year

## SPECIFY PERSON TO BE NOTIFIED IN CASE OF EMERGENCY:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Street

City, State/Country

Zip Code

**MEDICAL INSURANCE** (For entering undergraduate, academic year 2011-2012) If you will Continue to be covered by your parent's or other medical insurance, please indicate below.

Name of Insurance Plan \_\_\_\_\_ Policy# \_\_\_\_\_

## PARENTS OF STUDENTS UNDER 18 PLEASE COMPLETE THIS SECTION

I the undersigned, parent/legal guardian of \_\_\_\_\_, a minor, do hereby consent to an x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital service that may be rendered to said minor, under the instructions of the Caltech Medical Staff, whether such diagnosis or treatment is rendered at the office of said physicians or at a hospital licensed by the state of California

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date

Name: \_\_\_\_\_

**FAMILY MEDICAL HISTORY**

Please indicate all biological family members who have experienced any of the following conditions. If deceased, age at time of death. (i.e., Asthma, paternal grandfather, 96).

Biological family member \_\_\_\_\_ if deceased, age \_\_\_\_\_

Asthma \_\_\_\_\_

Cancer, (type) \_\_\_\_\_

High Blood Pressure \_\_\_\_\_

Diabetes \_\_\_\_\_

Heart Disease \_\_\_\_\_

High Cholesterol \_\_\_\_\_

Thyroid Condition \_\_\_\_\_

Tuberculosis \_\_\_\_\_

Alcoholism \_\_\_\_\_

Other serious chronic disease (specify) \_\_\_\_\_

**PERSONAL MEDICAL HISTORY:**

Any allergies (medication) \_\_\_\_\_ (food) \_\_\_\_\_ (others) \_\_\_\_\_

Tobacco Use \_\_\_ Yes \_\_\_ No \_\_\_ Pack a day \_\_\_ Years \_\_\_ I quit \_\_\_\_\_ ago  
\_\_\_\_\_ other tobacco products (specify) \_\_\_\_\_

Alcohol Use \_\_\_ Yes \_\_\_ No How Often \_\_\_\_\_ Quantity/Amount \_\_\_\_\_

List any surgery, hospitalizations (including psychiatric), illnesses, or significant injuries and approximate dates: \_\_\_\_\_  
\_\_\_\_\_

List any medications you are taking (including birth control pills/non-prescription pills):  
\_\_\_\_\_  
\_\_\_\_\_

Please describe any ongoing medical problem? \_\_\_\_\_  
\_\_\_\_\_

For women only: most recent pap and pelvic exam if any (date and result): \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Student's Signature**

\_\_\_\_\_  
**Date**

Name: \_\_\_\_\_

## PHYSICAL EXAMINATION

*(Within one year prior to admission)*

**All Information Is Required. Form Must Be Completed By A Health Care Provider**

Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_ Pulse \_\_\_\_\_

Skin: \_\_\_\_\_

Head: \_\_\_\_\_

Eyes: \_\_\_\_\_ Snellen R/20 \_\_\_\_\_ L/20 \_\_\_\_\_

Corrected R/20 \_\_\_\_\_ L/20 \_\_\_\_\_

Contact lens/glasses \_\_\_\_\_

Ears: \_\_\_\_\_

Nose: \_\_\_\_\_

Mouth and Throat: \_\_\_\_\_

Neck: \_\_\_\_\_

Thorax: \_\_\_\_\_ Lungs: \_\_\_\_\_

Breast: \_\_\_\_\_

Spine/Back: \_\_\_\_\_

Heart: \_\_\_\_\_

Abdomen: \_\_\_\_\_

Genito-urinary (if indicated) \_\_\_\_\_

Extremities: \_\_\_\_\_

Lymph Nodes: \_\_\_\_\_

Reflexes: \_\_\_\_\_

Laboratory exam: Hematocrit: \_\_\_\_\_ % urine sugar \_\_\_\_\_ urine protein \_\_\_\_\_

Does this student have a medical condition for which ongoing health care is required?

\_\_\_\_\_  
\_\_\_\_\_

May this student participate in athletic activities? Any restrictions or contraindications?

\_\_\_\_\_

Recommendations for health care at Caltech? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
**Signature of Health Care Provider**

\_\_\_\_\_  
**Date of Exam**

**Health Care Provider's Name** \_\_\_\_\_

Address \_\_\_\_\_

Tel. No. \_\_\_\_\_

Fax No. \_\_\_\_\_

# IMMUNIZATION RECORD

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Last first

Address: \_\_\_\_\_

To be completed and signed by your health care provider. *All information must be in English.*

**A. MMR (Measles, Mumps, Rubella) REQUIRED** (Two doses required)

1. Dose 1 given at age 12 months or later #1 \_\_\_\_\_  
mo/day/year
2. Dose 2 given at least 28 days after first dose #2 \_\_\_\_\_  
mo/day/year
- or
3. Report of positive immunity (attach copy of report) Immune \_\_\_\_\_ Not Immune \_\_\_\_\_

**B. Tuberculosis Screening (Mantoux) REQUIRED** within **SIX MONTHS PRIOR TO ADMISSION**

(A history of BCG vaccination should not preclude testing)

TB skin test \_\_\_\_\_ mm induration \_\_\_\_\_  
mo/day/year (required) signature of health care provider

**CXR (required if tuberculin skin test has a positive reaction >10mm) result:** \_\_\_\_\_ mm

Date of chest x-ray \_\_\_\_\_ Normal \_\_\_\_\_ Abnormal \_\_\_\_\_ if abnormal attach copy  
mo/day/year

**C. Tetanus-Diphtheria (Td) REQUIRED**

Primary series of four with DTaP or DTP \_\_\_\_\_  
year completed

Booster: Tdap (preferred) \_\_\_\_\_ or Td within the last ten years \_\_\_\_\_  
mo/day/year mo/day/year

**D. Hepatitis B –REQUIRED** (First 2 doses received prior to arrival at Caltech, third dose can be completed at Caltech)

Dose # 1 \_\_\_\_\_ Dose# 2 \_\_\_\_\_ Dose # 3 \_\_\_\_\_  
mo/day/year mo/day/year mo/day/year

OR Hepatitis B surface antibody (attach copy of report) Reactive \_\_\_\_\_ Non-reactive \_\_\_\_\_

**E. Meningococcal vaccine REQUIRED** for freshmen undergraduate students, persons with terminal deficiencies or asplenia. Non-freshmen college students under 25 years of age may choose to be vaccinated to reduce their risk of meningococcal disease.

(In the last 5 years) \_\_\_\_\_ Menactra (preferred) \_\_\_\_\_ Meonmune \_\_\_\_\_  
mo/day/year

**F. Hepatitis A (strongly recommended)** 2 doses at least 6-12 months apart (First dose prior to arrival at Caltech. Second dose can be completed at Caltech)

Dose# 1 \_\_\_\_\_ Dose #2 \_\_\_\_\_  
mo/day/year mo/day/year

**G. Polio (recommended)** Primary series should be complete \_\_\_\_\_ Booster if any \_\_\_\_\_  
year completed mo/day/year

**H. Varicella (recommended)** Either a positive varicella antibody, or two doses of vaccine given at least one month apart if immunized after age 13 years.

Dose # 1 \_\_\_\_\_ Dose # 2, given at least one month after first dose if age 13 years or older \_\_\_\_\_

OR Varicella antibody (attach copy of report) reactive \_\_\_\_\_ non-reactive \_\_\_\_\_

Health Care Provider \_\_\_\_\_ Date signed \_\_\_\_\_  
Address \_\_\_\_\_ Tel. No. \_\_\_\_\_

NAME \_\_\_\_\_

Have you ever experienced or are now experiencing any of the following (please check all that apply)?

Have you experienced or are now experiencing any of the following?	Have you Received Treatment?		Did Your treatment include (Please check all that apply)			Dates of Treatment
	Yes	No	Counseling	Meds	(list Medication)	
Anxiety <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Depression <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Eating Disorder:			<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Anorexia <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Bulimia <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Both <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Obsessive Compulsive Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Panic Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Phobia <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Do you plan to (circle one) continue, resume or begin receiving help for these problems while at Caltech  Yes  No

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## **MENINGITIS IMMUNIZATION ADVISORY AND NOTIFICATION**

Dear Student/Parent,

As the Medical Director of the Caltech Student Health Center, I am writing to inform you that legislation has been enacted in California (California Law AB 1452) requiring all new post secondary students receive the meningitis vaccine or sign a waiver after reading information about the risks of meningitis.

***What is meningococcal (meningitis) disease?*** Meningitis is rare, but when it strikes, this potentially fatal bacterial disease can lead to swelling of fluid surrounding the brain and spinal column and in some cases death. Symptoms range from flu like symptoms to permanent disabilities. Early diagnosis and treatment can prevent the most severe effects of meningitis, but the rapid progress of the illness and the similarity of its symptoms to the common flu often results in delayed treatment.

***How is the disease spread?*** Meningococcal meningitis is spread through the air via respiratory secretions or close contact with an infected person. This can include coughing, sneezing, kissing or sharing items such as utensils, cigarettes and drinking glasses.

***Who is at most risk for getting meningococcal disease?*** People who live in settings such as college dormitories are at risk, as are military recruits who live in close quarters, as well as people who travel to certain parts of the world where the disease is very common. Children and adults with damaged or removed spleens are also at risk.

***Are some students in college and post secondary schools at risks for meningococcal disease?*** College freshmen living in residence halls or dormitories are at an increased risk for meningococcal disease as compared to individuals of the same age not attending college. The setting, combined with risk behaviors such as alcohol consumption, exposure to cigarette smoke, sharing food or beverages, and activities involving exchange of saliva, may be what puts college students at a greater risk for infection.

The risks for meningococcal disease for other college students, in particular older students and students who do not live in congregate housing, is not increased. However, meningococcal vaccine is a safe and efficacious way to reduce their risk of contracting this disease.

***Is there a vaccine against meningococcal disease?*** Yes, there are currently 2 vaccines (Menomune – a polysaccharide vaccine and Menactra – a conjugate vaccine) available. Both of these vaccines provide protection against 4 of the serogroups of the bacteria, called groups A, C, Y and W 135. These 4 serogroups account for approximately two-thirds of the cases that occur in the U.S. each year. There is currently no vaccine for serogroup B which accounts for one-third of the cases. Protection from immunization with the meningococcal polysaccharide vaccine is not life-long; it last about 3 to 5 years. The meningococcal conjugate vaccine is expected to help decrease disease transmission and provide more long-term protection.

***Is the vaccine safe?*** The meningococcal vaccine has an excellent safety profile. However, like any medicine, is capable of causing serious problems such as severe allergic reactions. Some people who get the vaccine have mild side effects such as redness or pain where the shot was given. These symptoms usually last for 1 – 2 days. A small percentage of people who receive the vaccine develop a fever. Immunization is deferred during any acute illness and the vaccine is not given to pregnant women.

***Where can a student get vaccinated?*** Students and their parents should contact their healthcare provider and make an appointment to discuss meningococcal disease, the benefits and risk of vaccination, and the availability of these vaccines.

***Where can I get more information?*** More information about the disease and vaccine can be found at the following.

Centers of Disease Control and Prevention (CDC)  
[www.cdc.gov](http://www.cdc.gov)

American College health Association (ACHA)  
[www.acha.org](http://www.acha.org)

Meningitis Foundation of America  
[www.musa.org](http://www.musa.org)

***California Institute of Technology Vaccine Requirement.*** The Student Health Center requires all freshmen students receive meningitis vaccine or sign a waiver. Menactra is preferred but Menomune is acceptable if given within the past 3 years. Please have the meningitis immunization completed before arrival. If you have any questions contact 626-395-6393.

Sincerely.

Stuart C. Miller, M.D.  
Medical Director  
Caltech Health Center

CALIFORNIA INSTITUTE OF TECHNOLOGY  
ARCHIBALD YOUNG HEALTH CENTER

**MENINGITIS LETTER ACKNOWLEDGEMENT FORM**  
(Complete, Sign, and Return with Health Form)

I have read the letter on meningitis and flu vaccination clinic and:

- I intend to receive the meningococcal vaccine at:
  - My doctor's office
  - Caltech Student Health Center
- I do not intend to receive the vaccine
- I have already received the vaccine

\_\_\_\_\_  
Name (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

**Note: This release form is for the meningitis vaccination only.**