

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 2010-2011) 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	Yes	No	Counseling		Meds	(list Medication)
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Eating Disorder:								
Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Both	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Obsessive Compulsive Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Panic Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Phobia	<input type="checkbox"/>	<input type="checkbox"/>	<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: _____

California Institute of Technology
Archibald Young Health Center

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 the 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.

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.