



STUDENT HEALTH SERVICES

1239 Arden Rd. MC 1-8 Pasadena, CA 91125

Phone: (626) 395-6393 Fax: (626) 585-1522

STUDENT HEALTH FORM 2017-2018

Name _____
Last First Middle

Preferred Name/Also known as: _____ UID: _____

Check One: Undergraduate Graduate Other: _____

E-Mail Address _____ Date of Birth _____
month/day/year

PARENTS OF STUDENTS UNDER 18 PLEASE COMPLETE THIS SECTION:

In case of an emergency and if I cannot be reached I, the undersigned parent or guardian of the above named child, do hereby consent to any x-ray, anesthetic, medical, or surgical diagnosis or treatment and hospital care deemed advisable and rendered by any licensed physician or surgeon. This authorization is given in advance of any required care to empower a representative or other official of Caltech to give consent for such treatment as the physician may deem advisable. This authorization is effective unless revoked in writing. I accept full responsibility for any medical expenses incurred as a result of these actions.

Signature of Parent/Legal Guardian

Date

INFORMATION ABOUT HEALTH FORM SUBMISSION (Please read carefully)

Information on the health form will assist the Health Services staff provide high quality health care to all students. The Student Health Services office has a strict **CONFIDENTIALITY POLICY**. Information share is used solely by the Student Health Services office and will not be released to anyone without the student's consent.

Submission of the health forms are to be done in two parts: (1) Completion of the forms attached here by a physician and submitted to the Health Services office. (2) Completion of the online medical history by logging in to the My Caltech Health portal. Details and instructions on both parts are listed below.

INSTRUCTIONS PART 1: HEALTH FORMS BY A PHYSICIAN

1. Print a copy of this form and make medical appointments to have them filled out by a health physician.
2. Return completed form with documentation of required immunizations and copy of laboratory test results as indicated to the Student Health Services.
3. Forms can be returned via: (1) Mail to: Caltech Student Health Services, 1239 Arden Rd. MC 1-8, Pasadena, CA 91125; (2) Fax to: 626-585-1522; (3) Scan and email to: healthforms@caltech.edu

INSTRUCTIONS PART 2: MY CALTECH HEALTH PORTAL

Log onto the student health portal to complete your medical history. For instructions to complete this part please go to: https://healthcenter.caltech.edu/documents/31-part2_-_health_form_17-18.pdf

HEALTH FORM DEADLINE

Complete health information must be submitted by the following deadlines. Incomplete forms will not be processed and will result in a registration hold.

- Graduate Students due by July 14, 2017
- Undergraduate Athletes, International Students and early registrants due by July 30, 2017
- All other Undergraduate students due by August 31, 2017

Name: _____ Gender: _____ Date of Birth: _____

For NCAA Intercollegiate Athletes Only: Sport(s) _____

PHYSICAL EXAMINATION

(Within one year prior to September 1, 2017) All information is required.

NCAA Division III Athletes must be evaluated by a Medical Doctor (MD) or Doctor of Osteopathic Medicine (DO)

General Appearance Normal Abnormal

Height _____ Weight _____ Blood Pressure _____ Heart Rate _____ Marfan Stigmata Present Absent

Visual Acuity (Snellen, e.g., 20/40) Uncorrected: Left Eye ____/____ Right Eye ____/____ Glasses: Yes No

Corrected: Left Eye ____/____ Right Eye ____/____ Contacts: Yes No

| GENERAL | NORMAL | ABNORMAL | MUSCULOSKELETAL | NORMAL | ABNORMAL |
|------------------------|--------|----------|---------------------|--------|----------|
| HEAD/FACE | | | NECK | | |
| EYES | | | BACK | | |
| • MOVEMENTS/ NYSTAGMUS | | | SHOULDER/ARM | | |
| • PUPILS | | | ELBOW/FOREARM | | |
| EARS (HEARING) | | | WRIST/HAND/FINGER | | |
| NOSE | | | HIP/THIGH | | |
| MOUTH/THROAT | | | KNEE | | |
| NECK | | | LEG/ANKLE | | |
| RESPIRATORY | | | FOOT/TOES | | |
| CARDIOVASCULAR | | | GAIT (OPTIONAL) | | |
| • RHYTHM | | | NEUROLOGICAL | | |
| • SOUND | | | MYOTOMES | | |
| ABDOMEN | | | REFLEX TESTING | | |
| GENITOURINARY | | | DERMATOMES | | |
| SKIN | | | COMMENTS: | | |

CLINICAL TESTS

Sickle Cell Trait test result (optional) Negative Positive

EKG (contact Sports) (optional) _____

Current clinical and mental health issues for which ongoing health care is required? _____

Recommendations for continuing care at Caltech? _____

GENERAL ACTIVITIES CLEARANCE: May this student participate in physical activities; including physical education?

CLEARED TO PARTICIPATE

CLEARED WITH RECOMMENDATIONS (explain below)

NOT CLEARED (explain below)

Comments: _____

NCAA III Athletics Participation—REQUIRED FOR ALL STUDENT ATHLETES

CLEARED TO PARTICIPATE in all NCAA Division III intercollegiate athletic activities including strenuous weight training, conditioning, practices, and competitions without any restrictions or limitations.

CLEARED WITH RECOMMENDATIONS (explain below)

NOT CLEARED (explain below)

Comments: _____

Physician Signature (Parents or relatives of the student are not acceptable as providers of care)

Date of Exam

Health Care Provider's Name _____

Address _____

Telephone Number _____

Fax Number _____

Name: _____

Date of Birth: _____

IMMUNIZATION RECORD

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/dy/yr
- OR 3. Report of **POSITIVE** immunity (**attach copy of report**)
- 2. Dose 2 given at least 28 days after first dose: #2 _____
mo/dy/yr

B. Tetanus-Diphtheria-Pertussis REQUIRED

Primary series of four _____ Booster: Tdap preferred _____ Td _____
 with DTaP or DTP _____ (within the last 10 years) mo/dy/yr mo/dy/yr
 year completed

C. 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/dy/yr mo/dy/yr mo/dy/yr
 OR Report of **POSITIVE** Hepatitis B surface antibody (**attach copy of report**)

D. Meningococcal vaccine (ACY-W135) REQUIRED one dose (*no more than 5 years ago if Menactra or Menveo, and no more than 3 years ago for Menomune*). 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 risks of meningococcal disease. Menactra/Menveo: _____ Menomune: _____
mo/dy/yr mo/dy/yr

Meningitis B **STRONGLY RECOMMENDED** : Trumenba: _____ Bexsero: _____
 mo/dy/yr mo/dy/yr

E. 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/dy/yr mo/dy/yr

F. Polio (recommended)

Primary series _____ Booster if any _____
 year completed mo/dy/yr

G. Varicella (recommended) a positive varicella antibody or two doses of vaccine meets the requirement

Dose # 1 _____ Dose # 2 _____
 (given at least 12 weeks after the first dose ages 1-12 years and at least 4 weeks after the first dose if age 13 years or older)

OR **Positive Varicella antibody (attach copy of report)**

H. Human Papillovirus Vaccine (optional) three doses of vaccine for female or male college students 11 - 26 years

Dose # 1 _____ Dose #2 _____ Dose # 3 (if HPV 4) _____

Health Care Provider's Name _____

Address _____

Telephone Number _____ Fax Number _____

Name: _____

Date of Birth: _____

TUBERCULOSIS (TB) SCREENING/TESTING FORM (Required)

1. Country of birth: _____
2. To the best of your knowledge, have you had close contact with anyone who was sick with tuberculosis? o Yes o No
3. Were you born in one of the countries or territories on the list below? o Yes o No
4. Have you traveled or lived for more than one month in any of these countries or territories? o Yes o No

| | | | | | | |
|---------------------------|----------------------|---------------|------------------|------------------|---------------------|----------------------|
| Afghanistan | Burundi | Ethiopia | Korea-DPR | Micronesia | Poland | Syrian Arab Republic |
| Algeria | Cambodia | Fiji | Korea-Republic | Moldova-Rep. | Portugal | Taiwan |
| Angola | Cameroon | Gabon | Kuwait | Mongolia | Qatar | Tajikistan |
| Argentina | Cape Verde | Gambia | Kyrgyzstan | Morocco | Romania | Tanzania-UR |
| Armenia | Central African Rep. | Georgia | Lao PDR | Mozambique | Russian Federation | Thailand |
| Azerbaijan | Chad | Ghana | Latvia | Myanmar | Rwanda | Timor-Leste |
| Bahrain | China | Guam | Lesotho | Namibia | St. Vincent & | Togo |
| Bangladesh | Colombia | Guatemala | Liberia | Nauru | The Grenadines | Tunisia |
| Belarus | Comoros | Guinea | Libyan Arab | Nepal | Sao Tome & Principe | Turkey |
| Belize | Congo | Guinea-Bissau | Jamahinaya | Nicaragua | Saudi Arabia | Turkmenistan |
| Benin | Congo DR | Guyana | Lithuania | Niger | Senegal | Tuvalu |
| Bhutan | Cote d'Ivoire | Haiti | Macedonia-TFYR | Nigeria | Seychelles | Uganda |
| Bolivia | Croatia | Honduras | Madagascar | Niue | Sierra Leone | Ukraine |
| Bosnia & Herze- govina | Djibouti | India | Malawi | Pakistan | Singapore | Uruguay |
| Botswana | Dominican Republic | Indonesia | Malaysia | Palau | Solomon Islands | Uzbekistan |
| Brazil | Ecuador | Iraq | Maldives | Panama | Somalia | Vanuatu |
| Brunei Darussalam | El Salvador | Japan | Mali | Papua New Guinea | South Africa Spain | Venezuela |
| Bulgaria | Equatorial Guinea | Kazakhstan | Marshall Islands | Paraguay | Sri Lanka | Viet Nam |
| Burkina Faso | Eritrea | Kenya | Mauritania | Peru | Sudan | Zambia |
| | Estonia | Kiribati | Mauritius | Philippines | Suriname | Zimbabwe |

If you answered **YES** to any of the above screening questions, **you are required to submit a Mantoux 5TU PPD test date and or a copy of an Interferon Gamma Release Assay (IGRA) Quantiferon-TB Gold or TSPOT test**

- The test must have been performed within six months prior to your CIT registration date.
- Multiple-puncture TB tests are not acceptable (tine, HEAF, etc.).
- History of BCG is not a contraindication to TB testing.

If you answered **NO** to all of the above questions, **no further testing or further action is required.**

| |
|--|
| Mantoux 5TU test date: _____ mo/dy/yr |
| Result: _____ mm |

OR

| |
|--|
| (IGRA) Circle the specific method: QFT-G TSPOT |
| Test date: _____ mo/dy/yr |
| Result: _____ (include copy) |

If you have ever had tuberculosis or had a positive Mantoux PPD or Interferon Gamma Release Assay (IGRA) Quantiferon-TB Gold or TSPOT, your health care provider must do the following:

1. Attach a copy of a report for a chest X-ray that was taken on or after the positive result. This chest X-ray report **must be written in English** and dated within six months prior to entrance to CIT. (Do not send x-ray film)
2. Provide information about therapy. Start date: _____ Completion date: _____
mo/dy/yr mo/dy/yr
3. Declination of therapy? o Yes o No
4. Provide a clinical evaluation. Does the patient exhibit cough, hemoptysis, fever, chills, night sweats or weight loss?

oYes oNo If yes, please describe: _____

Parents or other relatives of the student are not acceptable as providers of care.

Signature (MD, NP, PA, RN, LVN)

Printed Name

Date

Address: _____ Phone _____ Fax _____