Caltech

STUDENT HEALTH CENTER
1239 Arden Rd. MC 1-8 Pasadena, CA 91125
Phone: (626) 395-6393 Fax:(626) 585-1522

HEALTH FORM 2016-2017

INSTRUCTIONS AND INFORMATION (Please read carefully)

1. Information on the health form will assist the Health Center staff provide high quality health care to all students.
2. Return completed form with documentation of required immunizations and copy of laboratory test results as indicated to the Student Health Center by **July 15. (Incomplete forms will not be processed and will result in a registration hold.)**
3. The Health Center has a strict **CONFIDENTIALITY POLICY.** Information shared is used solely by the Health Center and will not be released to anyone without the student's consent.

DEMOGRAPHICS (Please print legibly):

Check One: ☐ Undergraduate ☐ Graduate ☐ Other: ______________________________

Name ____
Last First Middle

Preferred Name/Also known as: ______________________________

Address ____
Street City, State/Country Zip Code

Home Phone Number ______________________ Cell Phone ______________________

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

Gender: ______________________ Pronouns: ______________________
(i.e. he/him/his, she/her/hers, they/their/theirs, etc.)

SPECIFY PERSON TO BE NOTIFIED IN CASE OF EMERGENCY:

Name ____

Relationship ______________________ Phone ______________________

Address ____
Street City, State/Country Zip Code

MEDICAL INSURANCE: (For entering undergraduates/graduates academic year 2016-2017)
If you are waiving the Caltech student health insurance plan please indicate your insurance information below and **submit a front and back copy of your insurance card.**

Name of Insurance Plan ______________________ Policy # ______________________

The Health Center is a free service for all enrolled Caltech students. We ask for the name of your insurance carrier in case we need to refer you for medical services outside of the Health Center.

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**

Name: ____ Date of Birth: ____________________

MEDICAL HISTORY

FAMILY MEDICAL HISTORY:
(high blood pressure, high cholesterol, cancer, diabetes, asthma, heart disease, stroke, heart disease, thyroid problems, alcoholism)

Family Member	Age	Known Health Problem	Age at Time of Death
Parent			
Parent			
Sibling			
Sibling			
Sibling			
Other			
Other			

PERSONAL MEDICAL HISTORY:
Please list allergies and describe reaction.

Medication ____

Food ____

Other ____

Cigarette Use: ☐ Yes ☐ No How many per day? ____________ How long have you been smoking? ________________

I quit ________________ago

Other Tobacco Products: ☐ Yes ☐ No If yes, please specify____

Alcoholic Beverages: ☐ Yes ☐ No How often ____________________ Quantity/Amount ______________________

List any serious illnesses, injuries, surgery and hospitalizations (including psychiatric) and approximate dates.

____

____

List any medications you are taking (including birth control, psychotropic medications, over the counter medications, vitamins and/or herbal supplements.)

____

____

Please describe any ongoing medical problem. ____

____

____ ________________________

Student's Signature (in English) **Date**

Name: ______________________________ Date of Birth: ______________

PHYSICAL EXAMINATION

(Within one year prior to September 1, 2016)

All information is required. Form must be completed by a health care provider.
(Parents or relatives of the student are not acceptable as providers of care)

Height: ________ Weight: ________ BMI: ________ BP: ________ Pulse: ________

Eyes: Snellen R/20 ______ L/20 ______ Corrected R/20 ____ L/20_____ Glasses: ☐ Yes ☐ No Contact Lens: ☐ Yes ☐ No

System	Findings: Normal	Findings: Abnormal	Comments	System	Findings: Normal	Findings: Abnormal	Comments
Abdomen	☐	☐	____________	Breast	☐	☐	____________
Cardio Vascular	☐	☐	____________	Chest	☐	☐	____________
Ears/Nose/Throat	☐	☐	____________	Genito-urinary	☐	☐	____________
Lungs	☐	☐	____________	Lymph Nodes	☐	☐	____________
Musculoskeletal	☐	☐	____________	Neck/Thyroid	☐	☐	____________
Peripheral Vascular	☐	☐	____________	Reflexes	☐	☐	____________

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 mental and/or physical health care at Caltech? ______________________

____

______________________________ ______________
Signature of Health Care Provider **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*
2. Dose 2 given at least 28 days after first dose: #2 ____________ *mo/dy/yr*

OR 3. Report of **POSITIVE** immunity **(attach copy of report)**

B. Tetanus-Diphtheria-Pertussis REQUIRED

Primary series of four with DTaP or DTP ______________ *year completed*

Booster: Tdap preferred _________________ *mo/dy/yr* Td ____________________ *mo/dy/yr*
(within the last 10 years)

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

Dose # 1 ____________ *mo/dy/yr* Dose# 2 _____________ *mo/dy/yr* Dose # 3 ____________ *mo/dy/yr*

OR Report of **POSITIVE** Hepatitis B surface antibody (**attach copy of report**)

D. Meningcoccocal 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: ______________ *mo/dy/yr* Menomune: ____________ *mo/dy/yr*

Meningitis B **STRONGLY RECOMMENDED** : Trumenba: ___________ *mo/dy/yr* Bexsero: ______________ *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 ____________________ *mo/dy/yr* Dose #2 _____________________ *mo/dy/yr*

F. Polio (recommended)

Primary series _________________________ *year completed* Booster if any ____________________________ *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? ☐ Yes ☐ No
3. Were you born in one of the countries or territories on the list below? ☐ Yes ☐ No
4. Have you traveled or lived for more than one month in any of these countries or territories? ☐ Yes ☐ No

Afghanistan
Algeria
Angola
Argentina
Armenia
Azerbaijan
Bahrain
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia
Bosnia & Herze-govina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cambodia
Cameroon
Cape Verde
Central African Rep.
Chad
China
Colombia
Comoros
Congo
Congo DR
Cote d'Ivoire
Croatia
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
Fiji
Gabon
Gambia
Georgia
Ghana
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Japan
Kazakhstan
Kenya
Kiribati
Korea-DPR
Korea-Republic
Kuwait
Kyrgyzstan
Lao PDR
Latvia
Lesotho
Liberia
Libyan Arab Jamahinaya
Lithuania
Macedonia-TFYR
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Micronesia
Moldova-Rep.
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Niue
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Romania
Russian Federation
Rwanda
St. Vincent & The Grenadines
Sao Tome & Principe
Saudi Arabia
Senegal
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa Spain
Sri Lanka
Sudan
Suriname
Syrian Arab Republic
Taiwan
Tajikistan
Tanzania-UR
Thailand
Timor-Leste
Togo
Tunisia
Turkey
Turkmenistan
Tuvalu
Uganda
Ukraine
Uruguay
Uzbekistan
Vanuatu
Venezuela
Viet Nam
Zambia
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: ______________ (mo/dy/yr) Completion date: ______________ (mo/dy/yr)
3. Declination of therapy? ☐ Yes ☐ No
4. Provide a clinical evaluation. Does the patient exhibit cough, hemoptysis, fever, chills, night sweats or weight loss?

   ☐Yes ☐No If yes, please describe: ____

P***arents 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** ______________

Name: ______________________________ Date of Birth: ______________

We ask about psychological health issues as we do physical health in order to assist you with your heath care needs.
Have you ever experienced or are now experiencing any of the following (please check all that apply)?

Have you experienced or are you now experiencing any of the following?			**Have you received <u>Treatment</u>?**		**<u>Did Your treatment include</u> (Please check all that apply)**			**<u>Dates of Treatment</u>**
	Yes	No	Yes	No	Counseling	Meds	(list medication)	
Anxiety	☐	☐	☐	☐	☐	☐	____________	________
Depression	☐	☐	☐	☐	☐	☐	____________	________
Bipolar Disorder	☐	☐	☐	☐	☐	☐	____________	________
Eating Disorder:								
Anorexia	☐	☐	☐	☐	☐	☐	____________	________
Bulimia	☐	☐	☐	☐	☐	☐	____________	________
Both	☐	☐	☐	☐	☐	☐	____________	________
Other	☐	☐	☐	☐	☐	☐	____________	________
Obsessive Compulsive Disorder	☐	☐	☐	☐	☐	☐	____________	________
Panic Disorder	☐	☐	☐	☐	☐	☐	____________	________
Phobia	☐	☐	☐	☐	☐	☐	____________	________

Other: Do you plan to continue, resume or begin receiving help for these concerns while at Caltech? ☐ Yes ☐ No

Comments:

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