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

HEALTH FORM 2017-2018

INSTRUCTIONS AND INFORMATION (Please read carefully)

1. Information on the health form will assist the Health Services 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 Services by **July 14. (Incomplete forms will not be processed and will result in a registration hold.)**
3. The Student Health Services office has a strict **CONFIDENTIALITY POLICY.** Information shared is used solely by the Student Health Services office and will not be released to anyone without the student's consent.

DEMOGRAPHICS (Please print legibly):

Check One: o Undergraduate o Graduate o 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 2017-2018)

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: _____ 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
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 _____ *(within the last 10 years)* *mo/dy/yr*

Td _____ *mo/dy/yr*

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? 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
	Dominican Republic	Indonesia	Malaysia	Palau	Solomon Islands	Uzbekistan
Botswana	Ecuador	Iraq	Maldives	Panama	Somalia	Vanuatu
Brazil	El Salvador	Japan	Mali	Papua New Guinea	South Africa Spain	Venezuela
Brunei Darussalam	Equatorial Guinea	Kazakhstan	Marshall Islands	Paraguay	Sri Lanka	Viet Nam
Bulgaria	Eritrea	Kenya	Mauritania	Peru	Sudan	Zambia
Burkina Faso	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: _____ mo/dy/yr Completion date: _____ 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: _____

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** _____