May 2015

Dear Claremont Colleges Student:

Congratulations and welcome to The Claremont Colleges (TCC) and your Student Health Services!

Attached is your Entrance Personal Health History/Medical Examination Report Form. This form provides your history of previous medical care from your private health care provider and is the basis for your continuing medical care in college. Completion in full regardless of your status (i.e. part-time, exchange, or transfer student) is required for registration at any of The Claremont Colleges.

Please complete pages one and two yourself. Pages three through five are to be completed by your private health care provider. Please note that required immunizations and screening include:

- Measles, Mumps, and Rubella (MMR)—two doses required
- Tetanus/Diphtheria—booster within the last 10 years
- Tuberculosis screening questionnaire (TB skin test, CXR, or Quantiferon blood test to be performed, if indicated)
- Meningococcal Tetravalent (Booster dose at age 16+)

Immunization records are required to prevent outbreaks of disease on campus as well as to help recognize students who are at risk should a disease outbreak occur. If you cannot locate your immunization records, you have two options:

- You can be re-immunized.
- You can have a blood test to determine immunity. If the blood test indicates that you are not immune to Measles, Mumps, and Rubella you will have to be re-immunized.

Once your form has been completed, mail or e-mail it directly to Student Health Services (shsrecords@cuc.claremont.edu).

All students are required to carry major medical insurance to provide supplemental coverage in the event of an acute injury or illness requiring hospitalization. A Student Health Insurance Plan (SHIP) is available to students attending TCC. Proof of insurance is required at all undergrad colleges and for all grad and undergrad International Students. The Claremont Colleges Insurance plan is required for all International Students. Please contact your Dean of Students’ Office for brochures and plan information.

The staff at Student Health Services looks forward to assisting you with your health care needs while you are at The Claremont Colleges. Our website, www.cuc.claremont.edu/shs/, has more information about our services.

Thank you for your cooperation. Your compliance helps protect the health of the entire campus community.

Sincerely,

Jennie Ho, M.D.
Director, Student Health Services
May 2015

Dear Students and Parents:

As the Director at Claremont University Consortium Student Health Services, I am writing to inform you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis, and the current recommendation from the Centers for Disease Control and Prevention (CDC) along with the recommendations of the Advisory Committee on Immunization Practices (ACIP).

In 1997, the CDC's Advisory Committee on Immunization Practices (ACIP) voted to recommend that college students, particularly freshmen living in dormitories and residence halls, be educated about meningitis and the benefits of vaccination. The panel based its recommendation on recent studies showing that college students, particularly freshmen living in dormitories, have a six-fold increased risk for meningitis. The recommendation further states that information about the disease and vaccination is appropriate for other undergraduate students who also wish to reduce their risk for the disease. This information again published in June 2000 and was included in the CDC's 2015 information and recommendations.

Meningitis is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. If not treated early, meningitis can lead to swelling of the fluid surrounding the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation, and even death.

Cases of meningitis among teens and young adults 15 to 24 years of age (the age of most college students) have more than doubled since 1991. The disease strikes about 3,000 Americans each year and claims about 300 lives. Between 100 and 125 meningitis cases occur on college campuses nationwide and as many as 15 students will die from the disease.

The Claremont Colleges, in an effort to keep the campus safe and as healthy as possible, now require all incoming freshmen to show proof of meningococcal vaccination. The vaccine is available at the Student Health Services any day by appointment. For more information, please feel free to contact our health service and/or consult the student's health care provider. You can also find information about this disease on our web site, www.cuc.claremont.edu/shs/, which links to the web site for the Centers for Disease Control and Prevention (CDC), http://www.cdc.gov/, and the American College Health Association web site, www.acha.org/Topics/meningitis.cfm.

Sincerely,

Jennie Ho, M.D.
Director, Student Health Service
In order to provide a safe and healthy environment at The Claremont Colleges, all students are required to complete this health record prior to entry.

IMPORTANT GENERAL INFORMATION

- Please read prior to completing this form:
  - Director’s letter of introduction
  - Information on meningococcal disease (Revised 2015)
- If documentation of immunization is unavailable, you must be re-immunized for measles, mumps, and rubella or show proof of immunity. Meningococcal vaccination is required.
- All forms may be submitted by mail to the above address or e-mail to shsrecords@cuc.claremont.edu.
- Please make a copy of this form for your records.

This form must be returned by August 1st for the fall semester and January 15th for the spring semester.

Part I: TO BE COMPLETED BY STUDENT  Use Ink & Print Clearly

Full Legal Name

Last                        First                                         Middle

Sex:  □  Male  □  Female  □  Not listed (Please Specify)          Date of Birth: ____________________________

Month             Day             Year

ID# ____________________________ Home Address ____________________________

Street

City     State    Zip Code   Country

Primary Phone (____) ____________________________ E-mail Address ____________________________

Emergency Contact:

Name ____________________________ Relationship ____________________________ Phone Number (Primary) (____) ____________________________

Address ____________________________ Phone Number (Work) (____) ____________________________

MEDICAL CARE AUTHORIZATION

I, the undersigned, hereby specifically authorize the Claremont University Consortium Student Health Services health care provider or whomever he or she may designate to administer any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, in serious or major illnesses or injuries without prior notification of the undersigned or any other person and without obtaining consent of the undersigned or any other person, if in the judgment of the physician or designee it is necessary for health care reasons to proceed with the treatment without delay. I further agree that the attending health care provider or whomever he or she may designate may evaluate and treat all other injuries or illnesses for which help is sought. In the case of a minor student, (under the age of 18), this treatment may proceed without prior notification of the undersigned parent or guardian. I further agree that the Student Health Services may release any medical information to other campus health care providers at Monsour Counseling and Psychological Services who may be providing care.

SIGNATURE OF STUDENT: All students must sign. If under 18 years of age, Parental Signature is also required.

STUDENT ____________________________ DATE __________

PARENT ____________________________ DATE __________

NOTE: A release of information must be signed and dated and on file for students 18 and older before any patient records and/or billing information may be released/discussed with a student, parent, guardian, spouse, or healthcare provider. A form is available at www.cuc.claremont.edu/shs/docs/SHS_Release_of_Medical_Records_Permission.pdf or at Student Health Services.
PART II: PERSONAL HEALTH HISTORY: TO BE COMPLETED BY STUDENT

<table>
<thead>
<tr>
<th>YES</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acne, severe</td>
<td>Genital warts (HPV)</td>
</tr>
<tr>
<td>Alcohol/Drug addiction</td>
<td>Headaches, frequent, severe</td>
</tr>
<tr>
<td>Allergies of any kind</td>
<td>Head injury</td>
</tr>
<tr>
<td>Anemia</td>
<td>Hearing difficulty</td>
</tr>
<tr>
<td>Anxiety or panic attacks</td>
<td>Heart disease</td>
</tr>
<tr>
<td>Arthritis</td>
<td>Heart murmur/Arrhythmia</td>
</tr>
<tr>
<td>Asthma, including exercise induced</td>
<td>Hepatitis</td>
</tr>
<tr>
<td>Attention deficit disorder/ADHD</td>
<td>High blood pressure</td>
</tr>
<tr>
<td>Back pain, chronic</td>
<td>Immune system problem</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>Kidney disease</td>
</tr>
<tr>
<td>Blood clotting disorder</td>
<td>Leukemia</td>
</tr>
<tr>
<td>Cancer</td>
<td>Loss of a paired organ</td>
</tr>
<tr>
<td>Chickenpox</td>
<td>(eye, kidney, testicle)</td>
</tr>
<tr>
<td>Crohn’s Disease/Ulcerative colitis</td>
<td>Meningitis/Encephalitis</td>
</tr>
<tr>
<td>Depression</td>
<td>Menstrual problems</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Mononucleosis</td>
</tr>
<tr>
<td>Ear, nose, or throat disorders</td>
<td>Ovarian cyst</td>
</tr>
<tr>
<td>Eating disorder</td>
<td>Pneumonia</td>
</tr>
<tr>
<td>Epilepsy/Seizures</td>
<td>Positive tuberculosis skin test</td>
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<tr>
<td>Fainting/Blackouts</td>
<td>Psychiatric treatment</td>
</tr>
<tr>
<td>Genital herpes</td>
<td>Sickle cell trait/disease</td>
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</table>

<table>
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<tr>
<th>YES</th>
<th>YES</th>
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</thead>
<tbody>
<tr>
<td>Self Injury</td>
<td>Thyroid condition</td>
</tr>
<tr>
<td>Urinary tract infection (recurrent)</td>
<td>Other</td>
</tr>
</tbody>
</table>

If you answered “YES” to any of the conditions listed above, please explain in the space below. Give the date and outcome of all conditions above or any other conditions or medical history not listed. You may attach additional sheets and old medical records if necessary.

_________________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________________

List all other surgical procedures, except fractures, with dates ____________________________

List all medical/psychiatric hospitalizations, with dates ____________________________

List all significant injuries and illnesses, with dates ____________________________

List any medications taken regularly ____________________________

List Allergy/Medication Reaction History ____________________________
It is required that all students be covered by medical insurance to provide supplemental coverage for medical costs in the event of a severe illness, injury, or accident. Claremont College requires each student to submit proof of coverage prior to registration. The Claremont University Consortium Student Health Services does not do any medical insurance billing. However, information about a student's medical coverage can expedite the process of community subspecialty referrals if necessary as well as an insurance identification card carried by the student. Please provide current medical insurance information below:

Name of Insurance Carrier __________________________________________________________

Policy Number(s) ______________________ Phone Number for Reporting Claims ___________________________
TO THE HEALTH CARE PROVIDER: Please review the health history provided by the student and add or complete anything of significance. After a complete physical examination, we would appreciate your evaluation of the student’s physical status, both for the student and as a basis for his/her continuing medical care.

Height ___________ Weight ___________ Pulse ___________ Blood Pressure ___________

Vision: (Uncorrected) R 20/_____  L 20/_____  (Corrected) R 20/____  L 20/____

List any allergies to medications or foods ____________________

<table>
<thead>
<tr>
<th>PHYSICAL EXAM</th>
<th>NORMAL</th>
<th>ABNORMAL</th>
<th>EXPLANATION OF ABNORMAL FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head/EENT</td>
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<td></td>
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<tr>
<td>Neck/Lymph/Thyroid</td>
<td></td>
<td></td>
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<tr>
<td>Cardiovascular</td>
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<tr>
<td>Respiratory</td>
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<td></td>
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<tr>
<td>Breast exam</td>
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<td></td>
<td></td>
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<tr>
<td>Abdomen</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Hernia/Testicles</td>
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<td></td>
<td></td>
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<tr>
<td>Musculo-skeletal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurologic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
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</tr>
</tbody>
</table>

A. TUBERCULOSIS SCREENING (Required)

1. Does the student have a history of a positive tuberculin skin test (PPD) in the past? □ Yes  □ No
   If no, proceed to #2.
   If yes, include date of positive PPD, mm induration, date and results of most recent chest x-ray and documentation of any treatment received for latent tuberculosis. **Skin test should not be repeated.** Proceed to #2.

2. Does the student have signs or symptoms of active tuberculosis disease? □ Yes  □ No
   If no, proceed to #3.
   If yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.

3. Is the student a member of a high-risk group? □ Yes  □ No
   Categories of high-risk students include those students who were born in or resided in countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Therefore students should undergo TB screening if they were born in or resided in countries EXCEPT those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia, USA, Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand. Other categories of high-risk students include those with HIV infection, who inject drugs, who have resided in, or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone ≥ 1 month) or other immunosuppressive disorders.

   If no, stop. Proceed to Section B.
   If yes, place tuberculin skin test [Mantoux only: Inject 0.1 ml of purified protein derivative (PPD) tuberculin containing 5 tuberculin units (TU) intradermally into the volar (inner) surface of the forearm]. A history of BCG vaccination should not preclude testing of a member of a high-risk group.

   Tuberculin Skin Test: (Must be performed within 6 months of arrival on campus)
   Date Placed: _______________  Date Read: _______________
   Result: _______________ (Record actual mm of induration, transverse diameter; if no induration, write “0”).
   Interpretation (Based on mm induration as well as risk factors.): □ Positive  □ Negative

4. Chest x-ray result (Required only if tuberculin skin test in #3 is positive): Date of CXR: ________________  □ Normal  □ Abnormal
PART V: IMMUNIZATION RECORD: TO BE COMPLETED BY THE HEALTH CARE PROVIDER

B. IMMUNIZATIONS (Please fill out below) OR Attach a copy of the Immunization Record

Tetanus, Diphtheria, Pertussis (DPT, Dtap, DT, Td, Tdap) REQUIRED
#1_________   #2__________ #3__________ #4__________   Booster within last 10 years ______________

Measles, Mumps, Rubella (MMR) (REQUIRED)
MMR #1_________ MMR #2_________ Or had disease verified by a health care provider Y      N
Immunity verified by immune titer (please include lab report)

Meningococcal Tetravalent (REQUIRED) Tetravalent conjugate (preferred) Date _____________
Tetravalent polysaccharide Booster _____________

Polio #1_________ #2_________ #3_________ #4_________ Last booster _____________

Hepatitis A #1_________ #2_________  
Hepatitis B #1_________ #2_________ #3_________ 

Human Papillomavirus (2, 4, or 9 valent) #1_________ #2_________ #3_________ 

Pneumococcal Polysaccharide vaccine Date _____________

Typhoid (Circle: Intramuscular/Oral) Date _____________

Varicella #1_________ #2_________ Disease (date) _____________

Yellow Fever Date _____________

List all medications you are prescribing for the patient __________________________________________________________________________

____________________________________________________________________________________

Please describe any current treatment and recommended further treatment ____________________________________________________________
________________________________________________________________________________________________________________________________________

Recommendations for intramural/intercollegiate physical activity

❑ May participate in sports without restrictions
❑ Should not participate in sports (please explain): _______________________________________________________________________

❑ May participate with the following restrictions: _______________________________________________________________________
❑ Medical or orthopedic problem must be evaluated before participation is allowed (please explain): _______________________________________________________________________

PART VI: HEALTH CARE PROVIDER SIGNATURE

Health Care Provider’s Name (please print)__________________________________________________________

Address ___________________________________________ Street ___________________________________________
City ___________________________________________ State ___________________________________________
Zip code ___________________________________________ Country ___________________________________________

Phone (______) __________________ Fax (______) __________________
Area code ___________________________________________ Area code ___________________________________________

Signature ___________________________________________ Date __________________