

Dear Claremont Colleges Students:

Congratulations, and welcome to The Claremont Colleges and the Student Health Service.

Attached is your **Entrance Personal Health History/Medical Examination Report Form**. This form provides your history of previous medical care from your private physician 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 RETURN AS SOON AS POSSIBLE. The deadline for submission is August 1, 2004 for those entering in the fall, and January 15, 2005 for those entering in the spring.**

Please complete pages one and two yourself. Take the form to your private physician for review of the history, physical examination and immunization requirements, pages three and four. 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 and/or CXR to be performed if indicated)

We **strongly recommend** the following immunizations:

- Hepatitis B
- Meningococcal Meningitis
- Varicella (chicken pox)- if you have not had the disease

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 several options.

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

Once your form is complete mail it directly to the Student Health Service. **Incomplete forms will be returned.** Remember to sign page 1 and have your health care provider sign page 4.

We recommend that all students carry major medical insurance to provide supplemental coverage in the event of an acute injury or illness requiring hospitalization. A low cost Student Accident and Sickness Medical Expense Insurance Plan is available to students attending the Colleges. Proof of insurance is required at Claremont McKenna, Harvey Mudd and Pitzer Colleges. At these three colleges, if there is no proof of insurance, enrollment in The Claremont Colleges Insurance Plan is automatic. Please contact your Dean of Students' Office for enrollment brochures and plan information. If you belong to a managed care plan (HMO), please speak with your insurance service representative regarding benefits for your medical care while away at college. Many managed care plans will not pay for non-emergency care if the patient is out of the service area or if care is provided by an "out-of-network" provider.

The staff at the Student Health Service look forward to assisting you with your health care needs while you are at The Claremont Colleges. Our website, [www.cuc.claremont.edu/shs/](http://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,

Valerie K. Novak M.D.  
Director, Student Health Service



## Student Health Service

175 East Sixth Street  
Claremont, CA 91711  
909 621-8222  
FAX: 909 621-8472

May, 1, 2004

Dear Students and Parents:

As the college health service director at The Claremont Colleges Student Health Service, 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).

On October 20, 1999, 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.

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.

A vaccine is available that protects against four types of the bacteria that cause meningitis in the United States — types A, C, Y and W-135. These types account for nearly two thirds of meningitis cases among college students.

The Student Health Service and the American College Health Association strongly recommend that all college students receive the vaccination against meningococcal meningitis. For more information, please feel free to contact our health service and/or consult your child's physician. You can also find information about the disease on our web site, [www.cuc.claremont.edu/shs/](http://www.cuc.claremont.edu/shs/), which links to the web site for The Centers For Disease Control and Prevention (CDC), [www.cdc.gov/ncidod/dbmd/diseaseinfo](http://www.cdc.gov/ncidod/dbmd/diseaseinfo), and the American College Health Association web site, [www.acha.org/projects\\_programs/men.cfm](http://www.acha.org/projects_programs/men.cfm).

The vaccine is available at the Student Health Service any day by appointment. We will also be sponsoring a walk-in vaccination clinic on October 26, 2004. You will receive further information about this clinic in the fall.

Sincerely,

Valerie K. Novak, M.D.  
Director, Student Health Service



**PART II: PERSONAL HEALTH HISTORY: TO BE COMPLETED BY STUDENT**

Have you ever, or do you now have any of the following?

YES

- Acne, severe
- Alcohol/ Drug addiction
- Allergies of any kind
- Anemia
- Anxiety or panic attacks
- Arthritis
- Asthma, including exercise induced
- Attention deficit disorder
- Backache, chronic
- Bipolar disorder
- Blood clotting disorder
- Cancer
- Chickenpox
- Crohn's/ Ulcerative colitis
- Depression
- Diabetes
- Ears, frequent infection
- Eating disorder
- Epilepsy/ Seizures
- Fainting/ Blackouts
- Hay fever, recurrent

YES

- Genital herpes
- Genital warts (HPV)
- Headaches, frequent, severe
- Head injury
- Hearing difficulty
- Heart disease/ Marfan's/ Other
- Heart murmur/ Arrhythmia
- Hepatitis
- High blood pressure
- Immune system problem
- Kidney disease
- Leukemia
- Loss of a paired organ (eye, kidney, testicle)
- Meningitis/ Encephalitis
- Menstrual problems
- Mononucleosis
- Ovarian cyst
- Pneumonia
- Positive tuberculin skin test
- Psychiatric treatment

YES

- Sickle Cell trait/ disease
- Sinus disease
- Thyroid condition
- Urinary tract infection
- Other

Do you have a family history of any of the following conditions? (parents, grandparents or siblings)

- Blood clotting disorder
- Cancer
- Diabetes
- Epilepsy
- Heart disease
- High blood pressure
- Kidney disease
- Marfan's/ Sudden Death
- Mental illness
- Migraine
- Rheumatoid arthritis
- Thyroid disease
- Other

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.

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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 \_\_\_\_\_

Do you have an Epi-pen? List Allergy/Reaction History \_\_\_\_\_

**HEALTH HABITS**

- Do you smoke cigarettes?  never  occasionally  regularly
- Do you examine your breasts monthly? (women)  never  occasionally  regularly
- Do you examine your testicles monthly? (men)  never  occasionally  regularly
- Do you use a seat belt/bicycle helmet consistently?  yes  no

We have a special concern for students who are experiencing problems with alcohol and drug use or abuse. The Health Education Outreach Department and Monsour Counseling Center are available to you for confidential counseling in these areas. In addition, Health Education Outreach provides information and confidential counseling about nutrition, eating concerns, stress management and sexual health.

**PART III: MEDICAL INSURANCE**

It is strongly recommended 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 McKenna College, Harvey Mudd College and Pitzer College require each student to submit proof of coverage prior to registration. **The Claremont University Consortium Student Health Service 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. Please provide any medical insurance information below.

Name of Insurance Carrier \_\_\_\_\_

Policy Number(s) \_\_\_\_\_ Phone Number for Reporting Claims \_\_\_\_\_

**Part IV: PHYSICAL EXAMINATION: TO BE COMPLETED BY THE HEALTH CARE PROVIDER**

*Form completed by family member/relative will not be accepted.*

**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 and emotional status, both for the student and as a basis for her/his continuing medical care.

Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Vision: Uncorrected R 20 \_\_\_\_\_ L 20 \_\_\_\_\_ Corrected R 20 \_\_\_\_\_ L 20 \_\_\_\_\_

Date of last Pap Test (if performed) \_\_\_\_\_ Results \_\_\_\_\_

List any allergies to medications or foods \_\_\_\_\_

PHYSICAL EXAM	NORMAL	ABNORMAL	EXPLANATION OF ABNORMAL FINDINGS
Head/ EENT			
Neck/ Lymph/Thyroid			
Cardiovascular			
Respiratory			
Breast exam			
Abdomen			
Hernia/Testicles			
Musculo-skeletal			
Neurologic			
Skin			

**PART V: IMMUNIZATION RECORD: TO BE COMPLETED BY THE HEALTH CARE PROVIDER**

**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 bypass, 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 chest x-ray: \_\_\_\_\_  Normal  Abnormal

*Immunization Section continues on the next page*

Patient Name \_\_\_\_\_

**B. REQUIRED IMMUNIZATIONS** (Please fill out below.)

**MMR** (measles/mumps/rubella) **DATE:** 1<sup>st</sup> dose \_\_\_\_\_ **DATE:** 2<sup>nd</sup> dose \_\_\_\_\_ **OR** Report of positive immunity (attach report)  
2 doses, one after age 4-6 Month \_\_\_\_\_ Year \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_

**TETANUS/DIPHTHERIA** **DATE:** 1<sup>st</sup> dose \_\_\_\_\_ **DATE:** 2<sup>nd</sup> dose \_\_\_\_\_ **DATE:** 3<sup>rd</sup> dose \_\_\_\_\_ **DATE:** 4<sup>th</sup> dose \_\_\_\_\_  
Primary series of at least 4 doses of DTP or DTaP Month \_\_\_\_\_ Year \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_  
**Td Booster** (within the last 10 years)  
Month \_\_\_\_\_ Year \_\_\_\_\_

**C. STRONGLY RECOMMENDED IMMUNIZATIONS**

**HEPATITIS B** **DATE:** 1<sup>st</sup> dose \_\_\_\_\_ **DATE:** 2<sup>nd</sup> dose \_\_\_\_\_ **DATE:** 3<sup>rd</sup> dose \_\_\_\_\_  
Series of 3 doses Month \_\_\_\_\_ Year \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_

**MENINGOCOCCAL** **DATE:** \_\_\_\_\_  
Quadrivalent Polysaccharide Vaccine Month \_\_\_\_\_ Year \_\_\_\_\_

**POLIO** **DATE:** 1<sup>st</sup> dose \_\_\_\_\_ **DATE:** 2<sup>nd</sup> dose \_\_\_\_\_ **DATE:** 3<sup>rd</sup> dose \_\_\_\_\_ **DATE:** 4<sup>th</sup> dose \_\_\_\_\_  
OPV / IPV (circle one) Month \_\_\_\_\_ Year \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_  
**CHICKEN POX** (Varicella) **DATE:** 1<sup>st</sup> dose \_\_\_\_\_ **DATE:** 2<sup>nd</sup> dose \_\_\_\_\_ **OR** Had disease \_\_\_\_\_  
If you have never had the disease Month \_\_\_\_\_ Year \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_

**D. OTHER IMMUNIZATIONS**

**HEPATITIS A** **DATE:** 1<sup>st</sup> dose \_\_\_\_\_ **DATE:** 2<sup>nd</sup> dose \_\_\_\_\_  
2 doses, 6-12 months apart Month \_\_\_\_\_ Year \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_

**YELLOW FEVER** **DATE:** \_\_\_\_\_  
Month \_\_\_\_\_ Year \_\_\_\_\_

**TYPHOID** **DATE:** \_\_\_\_\_  
Oral / Injection (circle one) Month \_\_\_\_\_ Year \_\_\_\_\_

List all medications you are prescribing for the patient

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe any current treatment and recommended further treatment

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Recommendations for intramural/intercollegiate physical activity

- Without restrictions
- Should not participate in sports
- May participate with the following restrictions: \_\_\_\_\_
- Medical or orthopedic problem must be evaluated before participation is allowed

**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 \_\_\_\_\_

Monsour Counseling Center would like to welcome you to our campus. This is an exciting time in your life and in order to provide optimum healthcare services for all of our students, we invite you to complete this short survey

*Information provided in this survey is confidential and access to any and all information is strictly limited to healthcare professionals at Student Health Services and Monsour Counseling Center.*

NAME: \_\_\_\_\_ College \_\_\_\_\_

Have you experienced, or are you now experiencing, any of the following?

(Please check all that apply)

			Have Received Treatment		Treatment Included:		Date Of Treatment(s)
	YES	NO	YES	NO	Counseling	MEDS	
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"/>	_____
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eating Disorders:							
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"/>	_____
Drug & Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Self-Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Have you been hospitalized for the above condition(s)? Yes  No  Date: \_\_\_\_\_

Do you plan to continue or to begin receiving treatment? Yes  No   
 College Facility                       Own Healthcare Provider

Would you like to be contacted by the Counseling Center?  
 YES - I would like to be contact by the Counseling Center  
 NO – I would not like to be contacted by the Counseling Center.

PLEASE RETURN COMPLETED FORM TO:  
 Student Health Services  
 175 East Sixth Street  
 Claremont, CA 91711  
 [FAX (909) 621-8472]