THE CLAREMONT COLLEGES
SERVICES

STUDENT HEALTH SERVICES

April 2021

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, two, and three yourself. Pages four, five, and six are to be completed by your private health care provider. Please note that ***required*** immunizations and screening include:

- ❑ COVID - completion of series
- ❑ Influenza vaccine – must complete vaccine no later than 09/30/2021
- ❑ Hepatitis B (HBV) - 3 dose series
- ❑ Measles, Mumps, and Rubella (MMR) - two dose series
- ❑ Meningococcal Conjugate (MCV4) and booster dose at or after age 16
- ❑ Primary series of Tetanus, Diphtheria, Pertussis and Tdap booster within the last 10 years
- ❑ Tuberculosis screening questionnaire (TB skin test, CXR, or Quantiferon blood test to be performed, if indicated)
- ❑ Varicella Zoster (VZV) - 2 dose series or date of 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 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 HBV, MMR, or VZV you will have to be re-immunized.

Once your form has been completed, mail it directly to Student Health Services at 757 College Way, Claremont, CA 91711, fax it to (909) 621-8472 or **upload your forms and medical records directly.**

Link to upload forms can be found at **https://bit.ly/2WfxT3m.**

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.services.claremont.edu/student-health-services** has more information about our services.

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

757 College Way, Claremont, CA, 91711
(909) 621-8222 • (909) 621-8472F

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This information is to inform you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis, and the current recommendations from the Centers for Disease Control and Prevention (CDC) along with the recommendations of the Advisory Committee on Immunization Practices (ACIP).

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. The disease strikes about 4000 Americans each year and claims about 500 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 Student Health Services any day by appointment. For more information, please feel free to contact our health service and/or consult your health care provider. You can also find information about this disease on our web site, **www.services.claremont.edu/shs/**, which links to the website for the Centers for Disease Control and Prevention (CDC), **http://www.cdc.gov/** and the American College Health Association website, **http://www.acha.org/meningitis**.

Please note that the required Meningococcal Tetravalent (Men ACWY) vaccination is different from the recommended Meningococcal B vaccination. All students need to have had a Meningococcal Tetravalent vaccination, with a booster dose given at age 16 or older. Meningococcal B vaccinations are strongly recommended for all students, but are not required at this time.

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THE CLAREMONT COLLEGES SERVICES

STUDENT HEALTH SERVICES

☐ Claremont McKenna College
☐ Harvey Mudd College
☐ Pitzer College
☐ Pomona College
☐ Scripps College

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:
  - SHS letter of introduction
  - Information on meningococcal disease
- If documentation of immunization is unavailable, you must be re-immunized for COVID-19, Hepatitis B, Measles, Mumps, Rubella, and Varicella Zoster or show proof of immunity. Meningococcal vaccination at or after age 16 and a Tdap booster within the last 10 years are required. Annual influenza vaccination is required by September 30, 2021.
- All forms may be submitted by mail to Student Health Services at 757 College Way, Claremont, CA 91711, by fax to (909) 621-8472, or uploaded directly to SHS at **https://bit.ly/2WfxT3m**.
- **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: PATIENT INFORMATION - TO BE COMPLETED BY STUDENT *Use Ink & Print Clearly*

Full Legal Name:

First:_____ Middle Initial:_____ Last:_____ Date of Birth: _____

Name Chosen:_____ Pronouns_____ Gender: _____

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 Colleges Services Student Health Services health care provider or whomever they 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 they 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 https://services.claremont.edu/wp-content/uploads/2020/08/Medical-Release-to-SHS.pdf or at Student Health Services.

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STUDENT HEALTH SERVICES

Patient Name _____

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

Have you ever been diagnosed with 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/ADHD
- ❑ Back pain, chronic
- ❑ Bipolar disorder
- ❑ Blood clotting disorder
- ❑ Cancer
- ❑ Chickenpox
- ❑ COVID-19
- ❑ Crohn's Disease/Ulcerative colitis
- ❑ Depression
- ❑ Diabetes
- ❑ Ear, nose, or throat disorders
- ❑ Eating disorder
- ❑ Epilepsy/Seizures
- ❑ Fainting/Blackouts
- ❑ Genital herpes

YES

- ❑ Genital warts (HPV)
- ❑ Headaches, frequent, severe
- ❑ Head injury
- ❑ Hearing difficulty
- ❑ Heart disease
- ❑ 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
- ❑ Sickle cell trait/disease

YES

- ❑ Self Injury
- ❑ Thyroid condition
- ❑ Urinary tract infection (recurrent)
- ❑ Other

_____

_____

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

- ❑ Blood clotting disorder
- ❑ Cancer
- ❑ Diabetes
- ❑ Heart disease
- ❑ High blood pressure
- ❑ Kidney disease
- ❑ Mental illness
- ❑ Migraine
- ❑ Rheumatoid arthritis
- ❑ Sudden death
- ❑ 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.

_____

_____

_____

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 _____

_____

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Patient Name _____

PART III: MEDICAL INSURANCE

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. **The Claremont Colleges Services 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.

Students of The Claremont Colleges are automatically enrolled into SHIP (Student Health Insurance Plan). Students wishing to waive SHIP coverage must submit proof of coverage prior to registration via the online waiver portal. Please note that this form is only for Student Health Service's use and does NOT waive you from SHIP. If you are not waiving SHIP coverage, please check the box below. Policy information will become available after the start of Fall semester.

Please provide current medical insurance information below:

I am enrolling into SHIP.

Name of Insurance Carrier _____

Policy Number(s)_____Phone Number for Reporting Claims _____

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STUDENT HEALTH SERVICES

Patient Name _____

Part IV: PHYSICAL EXAMINATION: TO BE COMPLETED BY A HEALTH CARE PROVIDER ONLY

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 status, both for the student and as a basis for their continuing medical care. Copy of physical completed in the last twelve months is accepted. Please check the appropriate box below.

☐ **Physical completed in the last 12 months attached. Complete Section B and sign at the bottom of the page.**

☐ **Physical completed below. Signature required at the bottom of the page.**

Section A.

Height _____ Weight _____ Pulse _____ Blood Pressure _____

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

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			

Section B.

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 IV: HEALTH CARE PROVIDER SIGNATURE

Provider Signature: _____ Date:_____

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STUDENT HEALTH SERVICES

Patient Name _____

PART V: TB SCREENING: TO BE COMPLETED BY THE HEALTH CARE PROVIDER

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 you have answered no to questions 1-3, please skip the following section and sign at the bottom of the page.

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

Or Interferon Gamma Release Assay (IGRA): Date Obtained:_____(Specify Method) ☐QFT-G ☐QFT-GIT ☐Other _____
Result: ☐ Positive ☐ Negative ☐ Intermediate

4. Chest x-ray result (Required only if tuberculin skin test in #3 or IGRA is positive): Date of CXR:_____ ☐ Normal ☐ Abnormal

PART V: HEALTH CARE PROVIDER SIGNATURE

Provider Signature: _____ Date: _____

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STUDENT HEALTH SERVICES

Patient Name _____

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

IMMUNIZATIONS – Please check appropriate box. ☐ Copy Attached ☐ Completed Below

COVID-19 #1_____#2_____ **(REQUIRED)**

Influenza (no later than 09/30/2021) #1 _____ **(REQUIRED)**

Hepatitis B #1_____#2_____#3_____**(REQUIRED)**

Tetanus, Diphtheria, Pertussis (DPT, Dtap, DT, Td, Tdap) (**REQUIRED)**

#1_____#2_____#3_____#4 _____ Tdap 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) or tetravalent polysaccharide #1_____ Booster Dose: _____

Varicella #1_____*#2*_____**(REQUIRED)** or Disease (date): _____

Recommended Immunizations

Meningococcal B Bexsero #1_____#2_____**or**
Trumemba #1 _____ #2 _____ #3_____

Polio #1_____#2_____#3_____#4_____Last booster: _____

Hepatitis A #1_____*#2*_____

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

Pneumococcal Polysaccharide vaccine Date_____

Prior Travel Immunizations

Typhoid (Circle: Oral/Intramuscular) Date: _____

Yellow Fever Date: _____

PART VI: HEALTH CARE PROVIDER SIGNATURE

Health Care Provider's Name (please print): _____

Address_____
Street City State Zip code Country

Phone (_____)_____ Fax (_____)_____

Signature_____ Date _____

Monsour Counseling & Psychological Services would like to welcome you to our campus!
This is an exciting time in your life. In order to provide optimum mental health services for all of our students, we invite you to complete this optional brief 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 & Psychological Services.

NAME:_____College _____

Have you experienced, or are you now experiencing, any of the following?
(Please check all that apply)

			Have Received Treatment		Treatment Included:	
	YES	**NO**	**YES**	**NO**	**Counseling**	**MEDS**
Anxiety	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐
Bipolar Disorder	☐	☐	☐	☐	☐	☐
Eating Disorder	☐	☐	☐	☐	☐	☐
Drug or Alcohol Abuse	☐	☐	☐	☐	☐	☐
Learning Disability	☐	☐	☐	☐	☐	☐
Other Mental Health Concern	☐	☐	☐	☐	☐	☐

Have you been hospitalized for the above condition(s)? Yes ☐ No ☐

Do you plan to continue or to begin receiving treatment? Yes ☐ No ☐
☐ MCAPS (on campus) ☐ Other Mental Health Professional (off campus)

If you would like to be contacted by a staff member at MCAPS after the fall semester begins, please indicate your preferred contact information here (cell phone or email):

_____

Please note: *Only give your contact information if you wish a staff member at MCAPS to contact you. Also please remember the security of email cannot be guaranteed, and as such it is not a confidential mode of communication.*

PLEASE RETURN COMPLETED FORM TO:
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757 College Way
Claremont, CA 91711
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