



Student Health Services
757 College Way
Claremont, CA 91711
(909) 621-8222 Fax (909) 621-8472

2022-23 Claremont Graduate University Entrance Health Forms

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 personal health care provider and is the basis for your continuing medical care on campus. **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.** This form must be submitted by July 15th for students beginning in the Fall semester and by January 15th for students beginning in the Spring semester.

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

- COVID – up-to-date on series
- Measles, Mumps, and Rubella (MMR) - two dose series
- 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 for MMR and VZV. If the blood test indicates you are not immune to MMR or VZV you will have to be re-immunized.

Student Health Services participates in the California Immunization Registry (CAIR). More information can be found at https://cairweb.org/docs/CAIR_Disclosure_Eng.pdf.

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 it directly to SHS at <https://bit.ly/2WfxT3m>.

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.



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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.



STUDENT HEALTH SERVICES

Claremont Graduate University

Medical History Report

All forms must be uploaded to SHS at <https://bit.ly/2WfxT3m>, mailed to 757 College Way, Claremont, CA 91711, or faxed to (909) 621-8472.

Date of Birth: _____ **DATE:** _____
Month Day Year Month Day Year

Name: _____ **Name Chosen:** _____
Last First Middle

Gender: _____ **Pronouns:** _____ **Phone:** _____

Address: _____
Street City State Zip

Person to notify in U.S. in case of an emergency: _____
Name Relationship Telephone

Street City State Zip

Medical Insurance Coverage – Required for all students

To protect against the potential major costs of accident or severe illness, all students are required to enroll in CGU's Student Health Insurance Plan unless eligible for a waiver or exemption. For waiver and exemption information, please visit <https://my.cgu.edu/health-insurance>. New students who plan to enroll in the university plan will receive their insurance information at the beginning of the academic term. Students with US based insurance, please provide your insurance policy information below:

Insurance Company: _____ Policy Number: _____

Phone number for reporting claims: _____

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. 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.

Student Signature: _____ Date: _____

NOTE: A release of information must be signed, dated, and on file for all students, regardless of age, before any patient records and/or billing information may be released/discussed with a parent, guardian, spouse, or healthcare provider. A form is available at <https://services.claremont.edu/wp-content/uploads/2021/09/ROI-092821.pdf> or at Student Health Services.



Medical History (If yes, please explain in the space provided.)

1. Do you have any medical problems, current or past? No Yes _____

2. Have you had any surgeries? No Yes _____

3. Are you currently taking any prescription or non-prescription (over the counter) medications (including birth control/contraception, herbal remedies, and inhalers)? No Yes _____

4. Do you have any allergies (medication, food, stinging insects, vaccinations, etc.)? No Yes _____

5. Have you ever, or are you currently being treated for depression, anxiety, bipolar disease, eating disorder (anorexia or bulimia), drug or alcohol abuse, schizophrenia or self-injury? No Yes _____

6. Do you get regular exercise? No Yes Type: _____
Frequency: _____ Duration: _____
7. Do you have any dietary restrictions? No Yes Vegetarian Vegan Other: _____
Do you feel you eat a healthy diet? No Yes
8. Do you drink alcohol? No Yes Average number of drinks per week: _____ Maximum drinks per day: _____
9. Do you use any recreational drugs? No Yes
10. Do you smoke? No Yes How many years have you smoked? _____ How many cigarettes per day? _____
Do you want to discuss smoking cessation methods? No Yes
11. How many hours of sleep do you average per night? _____
12. Are you currently sexually active? No Yes
(Sexually active means that you have been intimate or had sex with one or more partners, either currently or in the past. When a doctor asks if a patient is sexually active, they are usually trying to ascertain if the patient has had any sexually transmitted infections or pregnancy risks. If you answer yes, SHS recommends that you see a medical provider regarding contraception or testing for sexually transmitted infections.)
13. Do you have any current health concerns? No Yes _____

14. Have you ever been diagnosed with COVID-19? No Yes

Continue to next page

To be completed by Health Care Provider Only:

Tuberculosis screening

All students from high prevalence areas for tuberculosis, or otherwise high-risk, must have a health care provider complete the form below or submit a report documenting a negative tuberculin skin test, a negative (normal) chest x-ray, or Interferon Gamma Release Assay (blood test) from a health care provider. A student with a positive tuberculin skin test, current or past, must submit a chest x-ray report. The report must be written in English, have the date of the skin test, x-ray, or blood test and have the name and the signature of 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 N

High-risk groups include the following:

- Students who were born in or resided in countries where TB is endemic.
 - As it is easier to identify countries of low rather than high TB prevalence, students should undergo TB screening if they were born in or resided in countries **EXCEPT** 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.
- Students with HIV infection.
- Students who inject drugs.
- Students 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.
- Students with clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunioileal bypass, 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.

If you have answered yes to questions 1-3, please continue:

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 Indeterminate

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

Result: Positive Negative



STUDENT HEALTH SERVICES

*To be completed by Health Care Provider Only***Immunization Record: (Please fill out below OR attach copy of the immunization record)****Required**

COVID-19 Students must provide proof of vaccination, or approval for an exemption, at least 2 weeks prior to visiting campus. Complete even when uploading the Covid-19 vaccination card to Student Health Services.

_____ #1 _____ #2 _____ #3 Vaccine _____

MMR (measles/mumps/rubella) – dates of vaccine or laboratory report of immunity

#1 _____ #2 _____ #3 or Report of Positive Immunity

(Persons born before 1957 are considered immune; all others should receive at least one dose of MMR vaccine)

Td or Tdap (tetanus/diphtheria/pertussis) – booster recommended every ten years

Date of last immunization _____

Varicella (chickenpox) – history of disease or dates of vaccine or laboratory report of immunity

_____ #1 _____ #2 or Report of Positive Immunity _____ or Date of Disease _____

Recommended

Hepatitis B --

_____ #1 _____ #2 _____ #3

Hepatitis A --

_____ #1 _____ #2

Meningococcal Tetravalent (MCV4) Tetravalent conjugate (preferred)
Tetravalent polysaccharide

Date of last immunization _____
Booster _____

Human Papillomavirus (2, 4, or 9 valent)

_____ #1 _____ #2 _____ #3

Polio

_____ #1 _____ #2 _____ #3 _____ #4 _____ Last Booster

Influenza

Date of last immunization _____

Name of Health Care Provider (Please print): _____

Provider

Address: _____

Street

City

State

Zip

Provider Phone #: _____ **Provider Fax#** _____

Signature of provider: _____ **Date:** _____

Stamp of provider:

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	<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 Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug or Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Mental Health Concern	<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

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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