

CALIFORNIA INSTITUTE OF TECHNOLOGY

STUDENT HEALTH CENTER MAIL CODE 1-8

PASADENA, CALIFORNIA 91125

(626) 395-6393, Fax (626) 585-1522

INSTRUCTIONS AND INFORMATION:

1. The primary purpose of this form is to assure that immunizations are current and that the student poses no public health problems. It also provides a means of identifying students with special health needs and an historical basis for the provision of health care through the Student Health Service.
2. This form must be **returned to the Student Health Center by August 1. All sides of the form must be completed.** (Return the completed form in the envelope provided). **Partially completed form will not be processed.**
3. **Registration will be withheld until these forms are returned with documentation of required immunization and results of all laboratory tests as indicated.**
4. Information on this form is **CONFIDENTIAL** and to be used solely for the Health Services, and will not be released without the student's consent.

PERSONAL HISTORY (To be filled out by applicant)

NAME _____

Last

First

Middle

HOME ADDRESS _____

Street

City, State/Country

Zip Code

HOME PHONE NUMBER (Include area code) _____

E-MAIL ADDRESS (if available) _____

SEX: Female _____ Undergraduate _____ Soc. Security No _____

Male _____ Graduate _____ Date of Birth _____

month/day/year

SPECIFY PERSON TO BE NOTIFIED IN CASE OF EMERGENCY:

Name _____ Relationship _____ Tel. No. _____

Address _____

Street

City, State/Country

Zip Code

MEDICAL INSURANCE

*All Caltech students are automatically enrolled in a comprehensive medical plan. If you will continue to be covered by your parent's or other medical insurance, please indicate below. **Your Caltech insurance will become your primary insurer.***

PARENTS OF STUDENTS UNDER 18 PLEASE COMPLETE THIS SECTION

I the undersigned, parent/legal guardian of _____, a minor, do hereby consent to an x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital service that may be rendered to said minor, under the instructions of the Caltech Medical Staff, whether such diagnosis or treatment is rendered at the office of said physicians or at a hospital licensed by the state of California.

Signature of Parent/Legal Guardian

Date

Name: _____

FAMILY MEDICAL HISTORY: Please indicate all biological family members who have experienced any of the following conditions. If deceased, age at time of death. (i.e., Asthma, paternal grandfather, 96).

	Biological family member	if deceased, age
Asthma	_____	_____
Cancer, (type)	_____	_____
High Blood Pressure	_____	_____
Diabetes	_____	_____
Heart Disease	_____	_____
High Cholesterol	_____	_____
Thyroid Condition	_____	_____
Tuberculosis	_____	_____
Alcoholism	_____	_____
Other serious chronic disease (specify)	_____	_____

PERSONAL MEDICAL HISTORY:

Any allergies (medication) _____ (food) _____ (others) _____

Tobacco Use ___ Yes ___ No ___ Pack a day ___ Years ___ I quit _____ ago
_____ other tobacco products (specify) _____

Alcohol Use ___ Yes ___ No How Often _____ Quantity/Amount _____

List any surgery, hospitalizations (including psychiatric), illnesses, or significant injuries and approximate dates: _____

List any medications you are taking (including birth control pills/non-prescription pills):

Please describe any ongoing medical problem? _____

For women only: most recent pap and pelvic exam if any (date and result): _____

Student's Signature

Date

Name: _____

PHYSICAL EXAMINATION

(Within one year prior to admission)

All Information Is Required. Form Must Be Completed By A Health Care Provider

Height _____ Weight _____ BP _____ Pulse _____

Skin: _____

Head: _____

Eyes: _____ Snellen R/20 _____ L/20 _____

Corrected R/20 _____ L/20 _____

Contact lens/glasses _____

Ears: _____

Nose: _____

Mouth and Throat: _____

Neck: _____

Thorax: _____ Lungs: _____

Breast: _____

Spine/Back: _____

Heart: _____

Abdomen: _____

Genito-urinary (if indicated) _____

Extremities: _____

Lymph Nodes: _____

Reflexes: _____

Laboratory exam: Hematocrit: _____% urine sugar _____ urine protein _____

Does this student have a medical condition for which ongoing health care is required?

May this student participate in athletic activities? Any restrictions or contraindications?

Recommendations for health care at Caltech? _____

Signature of Health Care Provider

Date of Exam

Health Care Provider's Name _____

Address _____

Tel No. _____

Fax No. _____

IMMUNIZATION RECORD

Name: _____ Soc. Security No: _____
last first

Address: _____ Birthdate: _____

To be **completed** and **signed** by your health care provider. *All information must be in English.*

A. Measles (rubeola) REQUIRED

a. Dose 1 given at age 12–15 months or later, Dose 2 given at age _____ Dose # 1 _____ Dose #2 _____
4–6 years or later, and at least one month apart from the first dose **or**
b. Report of positive immunity (attach copy of report) Date of test _____ Immune ___ Not Immune _____

B. Rubella immunity REQUIRED

a. One immunization after the first birthday, **or** Dose # 1 _____ Dose # 2 _____
b. Report of positive immunity (attach copy of report) Date of test _____ Immune ___ Not Immune _____

C. Mumps immunity REQUIRED

a. One immunization after the first birthday, **or** Dose # 1 _____ Dose # 2 _____
b. Report of positive immunity (attach copy of report) Date of test _____ Immune ___ Not Immune _____

signature of health provider

D. Tuberculosis Screening (Mantoux) REQUIRED within SIX MONTHS PRIOR TO ADMISSION

TB skin test _____ mm indurations _____
mo/day/yr (required) signature of health care provider

CXR required if the student has had tuberculosis, has had BCG within the last 5 years, or has a positive reaction (>10mm)

X-ray result: Normal _____ Abnormal _____
month/ year

E. Tetanus-Diphtheria (Td) REQUIRED

Primary series of four with DTaP or DTP _____ TD booster within the last ten years _____
year completed mo/ day/ yr

F. Hepatitis B immunity REQUIRED (First two doses received prior to arrival at Caltech. Third dose can be completed at Caltech)

Three doses, **or** Dose#1 _____ Dose#2 _____ Dose#3 _____
Proof of Immunity (attach copy of report) _____ Reactive _____ Non-reactive _____

G. Meningococcal vaccine (strongly recommended) _____ (vaccine is available at Caltech)

H. Polio (optional) Primary series should be complete _____ Booster if any _____
year completed mo/day/year

I. Varicella (optional) Either a positive varicella antibody, or two doses of vaccine given at least one month apart if immunized after age 13 years.

Dose # 1 _____ Dose # 2, given at least one month after first dose if age 13 years or older _____ **or**
Varicella antibody (attach copy of report) reactive _____ non-reactive _____

Physician/Nurse Practitioner _____ Date signed _____
Address _____ Tel. No. _____

ADDENDUM

NAME _____

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

Have you experienced or are now experiencing any of the following?	Have you Received Treatment?		Did Your treatment include (Please check all that apply)			Dates of Treatment
	Yes	No	Counseling	Meds	(list Medication)	
Anxiety	<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"/>	_____	_____
Eating Disorder:			<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Anorexia	<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"/>	_____	_____
Both	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Obsessive Compulsive Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Panic Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Phobia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Do you plan to continue, resume or begin receiving help for these problems? Yes No

Comments: _____

MENINGITIS AND FLU VACCINATION CLINIC

Dear Student/Parent,

As the Medical Director of the Caltech Student Health Center, I am writing to inform you about an important opportunity that you have to protect yourself against a serious health hazard facing college students. I am referring to the growing threat of **meningococcal meningitis**, commonly referred to as meningitis, on college campuses across the country.

Meningitis is a serious disease, the effects of which range from flu like symptoms to permanent disabilities and in some cases death. Early diagnosis and treatment can prevent the most severe effects of meningitis, but the rapid progress of the illness and the similarity of its symptoms to the common flu often results in delayed treatment. While there have been no cases of meningitis on the Caltech campus, the Health Center will offer a vaccine program to prevent an outbreak of the illness.

Who is at risk of contracting meningitis? Recent studies of college outbreaks suggest that freshmen living in residence halls may be at highest risk among college students of contracting this disease. Risk factors for contracting meningitis include close living and working conditions and lifestyle behaviors such as; exposure to active and passive smoking, alcohol consumption, and bar patronage. Because of these findings, the U.S. Centers for Disease Control and Prevention (CDC), as well as the American College Health Association, recommend that students in this group be informed of their risk of contracting the disease, the potential benefits of vaccination, and the vaccine be made available to them. The Student Health Center will be providing meningitis vaccination in response to their recommendations. Adverse reactions to the vaccine are uncommon, but could include pain and redness at the injection site for one or two days. For some recipients, vaccine components can cause an allergic reaction.

The meningitis vaccine will be available at the Student Health Center starting Sunday, September 17, 2006, from 9:00 am – 12 noon, and continuing to October 13, 2006, Monday through Friday, 8:00 am – 12 noon. No appointment is necessary. In addition a flu vaccine clinic is being planned for mid October to mid November, date and time to be announced later.

Attached to this letter is an acknowledgement form for the meningitis vaccination. The meningitis vaccination form **must be completed, signed and returned to the Health Center with the Health Form.**

I encourage you to learn more about meningitis and the vaccine by visiting the following websites:

Centers for Disease Control and Prevention (CDC):

<http://www.cdc.gov/ncidod/dbmd/diseaseinfo/meningococcal.g.htm>

American College Health Association (ACHA):

http://www.acha.org/projects_programs/men.cfm

http://www.acha.org/info_resources/guidelines.cfm

Meningitis Foundation of America:

<http://www.musa.org/welcome.htm>

Sincerely,

Stuart C. Miller, M.D.
Medical Director
Caltech Health Center

CALIFORNIA INSTITUTE OF TECHNOLOGY
ARCHIBALD YOUNG HEALTH CENTER

MENINGITIS LETTER ACKNOWLEDGEMENT FORM
(Complete, Sign, and Return with Health Form)

I have read the letter on meningitis and flu vaccination clinic and:

- I intend to receive the meningococcal vaccine at:
 - My doctor's office
 - Caltech Student Health Center
- I do not intend to receive the vaccine
- I have already received the vaccine

Name (Print)

Date

Signature

Note: This release form is for the meningitis vaccination only.