

CALIFORNIA INSTITUTE OF TECHNOLOGY  
STUDENT HEALTH CENTER  
MAIL CODE 1-8  
PASADENA, CALIFORNIA 91125  
(626)395-6393, Fax (626)585-1522

The Archibald Young Student Health Center is committed to providing caring, compassionate and cost effective medical care and health promotion services that are specifically designed for the unique needs of our students. The medical staff consists of highly qualified physicians and nurse practitioners that provide competent diagnosis and treatment of most acute illnesses and injuries, including some urgent care and continuity care. The medical staff acts as your primary health care providers. In addition to meeting your basic health care needs, the clinicians are an excellent resource for other health concerns. Visit the health center if you need medical care or assistance.

A variety of services that address the primary health care needs of college students are available to all registered students and their spouses enrolled in the Spouse Program. Some of the services are:

- Medical Consultation and Referral
- Laboratory Tests
- Radiology Services (provided off-site)
- Pharmacy/Prescription Services
- Allergy/Injection Clinic
- Women's Health Clinic
- Dermatology Clinic
- Travel and Immunization Clinic
- Orthopedic Clinic
- Health Education and Preventive Health Care

The health center is open year round. Our office hours are Monday to Thursday from 8:00 a.m. to 5:00 p.m. and on Friday from 8:00 a.m. to 4:00 p.m. The center extends it's hours for the dermatology and orthopedic clinics.

All registered students are covered by the Student Health Insurance Plan. The plan supplements the health care services provided by the Student Health Center. For more information visit:  
[www.chickering.com/stu\\_conn/student\\_connection.aspx?group\\_number=812843](http://www.chickering.com/stu_conn/student_connection.aspx?group_number=812843)

For more information about the Student Health Center call (626) 395-6393 or visit [www.healthcenter.caltech.edu](http://www.healthcenter.caltech.edu).

# 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 pages 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 \_\_\_\_\_  
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.***

Name of Insurance Plan \_\_\_\_\_ Policy# \_\_\_\_\_

## 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: \_\_\_\_\_

Last

first

Middle

Address: \_\_\_\_\_ Birthdate: \_\_\_\_\_

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

## A. MMR (Measles, Mumps, Rubella) REQUIRED

(Two doses required)

1. Dose 1 given at age 12 months or later #1 \_\_\_\_\_

mo/day/year

2. Dose 2 given at least 28 days after first dose #2 \_\_\_\_\_

mo/day/year

or

3. Report of positive immunity (attach copy of report) Immune \_\_\_\_\_ Not Immune \_\_\_\_\_

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

(A history of BCG vaccination should not preclude testing)

TB skin test \_\_\_\_\_ mm induration \_\_\_\_\_

mo/day/year

(required)

signature of health care provider

CXR (required if tuberculin skin test has a positive reaction >10mm) result: \_\_\_\_\_ mm

Date of chest x-ray \_\_\_\_\_ Normal \_\_\_\_\_ Abnormal \_\_\_\_\_ if abnormal attach copy

mo/day/year

## C. Tetanus-Diphtheria (Td) REQUIRED

Primary series of four with DTaP or DTP \_\_\_\_\_

year completed

Booster: Tdap (preferred) \_\_\_\_\_ or Td within the last ten years \_\_\_\_\_

mo/day/year

mo/day/year

## D. Hepatitis B –REQUIRED (First 2 doses received prior to arrival at Caltech, third dose can be completed at Caltech)

Dose # 1 \_\_\_\_\_ Dose# 2 \_\_\_\_\_ Dose # 3 \_\_\_\_\_ or

mo/day/year

mo/day/year

mo/day/year

Hepatitis B surface antibody (attach copy of report) Reactive \_\_\_\_\_ Non-reactive \_\_\_\_\_

**E. Meningococcal vaccine REQUIRED** one dose for freshmen undergraduate students, persons with terminal deficiencies or asplenia. Non-freshmen college students under 25 years of age may choose to be vaccinated to reduce their risk of meningococcal disease.

Date \_\_\_\_\_ Menomune \_\_\_\_\_ Menactra \_\_\_\_\_

mo/day/year

**F. Hepatitis A (strongly recommended)** 2 doses at least 6-12 months apart (First dose prior to arrival at Caltech. Second dose can be completed at Caltech)

Dose# 1 \_\_\_\_\_ Dose #2 \_\_\_\_\_

mo/day/year

mo/day/year

**G. Polio (recommended)** Primary series should be complete \_\_\_\_\_ Booster if any \_\_\_\_\_

year completed

mo/day/year

**H. Varicella (recommended)** 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 \_\_\_\_\_

Health Care Provider \_\_\_\_\_ 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	Yes	No	Counseling    Meds    (list Medication)	
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> _____	_____
Depression/ 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"/> _____	_____
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"/> _____	_____
Both	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/> <input type="checkbox"/> _____	_____
Panic Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/> <input type="checkbox"/> _____	_____

Do you plan to (circle one) continue, resume or begin receiving help for these problems while at Caltech

Yes  No

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

