PEPPERDINE
UNIVERSITY
Student Health Center

GRADUATE & LAW HEALTH HISTORY

THIS FORM IS REQUIRED FOR INTERNATIONAL STUDENTS
REGISTRATION AND ATTENDANCE
Fax to Student Health Center when complete (Fax: 310-506-4588)

PART 1: PERSONAL DATA: To be filled out by student

All information reported here is confidential and kept as part of your health record in the Student Health Center under HIPPA (Health Insurance Portability and Accountability Act) guidelines.

Today's Date___/___/___

NAME Last First Middle	Sex	DATE OF BIRTH	MARITAL STATUS	I.D.#

HOME ADDRESS	CITY/STATE/ZIP CODE	PHONE NO. ( )

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY	RELATIONSHIP	PHONE NO. ( )

ADDRESS	CITY/STATE/ZIP CODE

NAME OF PERSONAL PHYSICIAN	PHONE NO. ( )

ADDRESS	CITY/STATE/ZIP CODE

ETHNICITY (optional): ☐ African American/Black ☐Hispanic ☐ Caucasian/White ☐ Asian American/Asian
☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Multi-racial/Other

PART 2: PERMISSION FOR TREATMENT AND RELEASE OF INFORMATION: To be filled out by student

In case of routine health examinations, immunizations, diagnostic procedures, treatment of illnesses and/or injuries, permission is hereby granted to treat the student named herein at the Student Health Center, Pepperdine University, and to make necessary referrals for emergency transport or to private physicians, specialists, psychologists, counselors, and/or other community facilities as his/her condition may dictate.

X_____ **SIGNATURE OF STUDENT**

X_____ **SIGNATURE OF PARENT**
Parental endorsement required if student is under 18 years of age.

PART 3: HEALTH INSURANCE REQUIREMENT: To be filled out by student

All MALIBU students are required to have a current health insurance policy while attending school. **The Electronic Waiver must be submitted at http://services.pepperdine.edu/healthcenter/geninfo/insurance.htm to avoid being enrolled in, and charged for, the University Student Health Insurance.**

Please provide the following information and sign below.

NAME OF INSURED

NAME OF INSURANCE COMPANY	PHONE NO. ( )

IF A GROUP INSURANCE POLICY, NAME OF GROUP	POLICY OR GROUP NO.

PHARMACY CO-PAY ☐ YES ☐ NO AMOUNT _____

SIGNATURE	DATE

PART 4: PERSONAL HEALTH HISTORY: To be filled out by student

ALLERGIES TO MEDICATIONS

WHAT MEDICAL CONDITIONS HAVE REQUIRED CARE, INCLUDING PERSONAL COUNSELING OR PSYCHOTHERAPY DURING THE PAST 5 YEARS

LIST MEDICATIONS TAKEN RECENTLY OR CURRENTLY

LIST ANY OPERATIONS YOU HAVE HAD AND YEAR (include tonsils, appendix, hernia, etc.)

OTHER HOSPITALIZATIONS, INCLUDING PSYCHIATRIC HOSPITALIZATIONS (include reason and year)

Please indicate if you have ever had any of the following:

☐ Heart Disease_____	☐ Stroke_____	☐ Epilepsy_____	☐ Thyroid Disease_____
☐ Kidney Disease_____	☐ Schizophrenia_____	☐ Suicide attempt _____	☐ Tuberculosis_____
☐ Blood Disease_____	☐ Migraine Headache_____	☐ Diabetes_____	☐ Eating Disorder_____
☐ Asthma_____	☐ Severe Depression_____	☐ Cancer_____	☐ Other (please explain) _____

PART 5: IMMUNIZATION RECORD: To be filled out and signed by a licensed medical provider (MD, PA, or NP), or by student

RECOMMENDED TUBERCULOSIS SCREENING

1. Has the student ever had a positive TB screening test? ☐Yes ☐No
   If yes, mm induration _____
2. Has the student ever had contact with anyone sick with tuberculosis? ☐Yes ☐No
3. Was the student born in or had significant travel in any of the countries listed on the end of this form? (Significant travel is considered a stay for at least 1 week with substantial exposure to the indigenous population) ☐Yes ☐No
4. Has the student ever been vaccinated with BCG? (Note: BCG vaccine is not available in the U.S.) ☐Yes ☐No
5. Does the student have immunosuppression due to chronic steroid use, HIV, anti-cancer drugs or other causes? ☐Yes ☐No

If the answer to ALL of the above questions is "No," please skip to RECOMMENDED IMMUNIZATIONS
If the answer to ANY of the above questions is "Yes," further testing is recommended as follows:

If the answer to question #1 is "yes" and the positive screening test performed was an Interferon Gamma Release Assay (IGRA) test, such as a T-spot or Quantiferon-TB Gold Test, then a CXR is recommended within the past year. (Note: If student has completed treatment for latent TB, please contact the Pepperdine Student Health Center at (310) 506-4316 option #3 for further instruction).

CXR: Abnormal ☐ Normal ☐ Date obtained ___/___/___

If the answer to question #1 was "yes" and the screening test performed was a PPD OR the answer to any question #2-4 was "yes", the following is recommended:

1. An Interferon Gamma Release Assay (IGRA) such as a T-spot or Quantiferon–TB Gold Test within the past year. If test unavailable, student will be able to obtain on arrival at Pepperdine. Note: If student has completed treatment for latent TB, please contact the Pepperdine Student Health Center at 310-506-4316 option #3 for further instruction.)
   IGRA test date ___/___/___ Results: Positive ☐ Negative ☐

2. If IGRA test is positive, a CXR is recommended AND an appointment with the Pepperdine Student Health Center medical provider.
   CXR: Abnormal ☐ Normal ☐ Date obtained ___/___/___

RECOMMENDED IMMUNIZATIONS:

Tetanus/diphtheria/pertussis: Booster containing pertussis within past ten years ___/___/___ Type: **Tdap**☐ or only **Td**☐

Hepatitis B: Three doses required
1st Dose ___/___/___ **2nd Dose** ___/___/___ **3rd Dose** ___/___/___
or positive titer showing immunity ___/___/___

Hepatitis A: Two doses
1st Dose ___/___/___ **2nd Dose** __/___/___

Meningitis Vaccine: Primary injection or booster ≥16 years of age.
Date Received ___/___/___

MMR-Measles, Mumps, Rubella: Two doses required
1st Dose ___/___/___ **2nd Dose** ___/___/___
or positive titer showing immunity ___/___/___

Varicella: Two doses or history of disease
1st Dose ___/___/___ **2nd Dose** ___/___/___
or Disease ___/___/__

Name of medical provider, if applicable — Phone number of provider

X _____
Signature of medical provider, if applicable — Date

X _____
Signature of student — Date

Afghanistan	Congo DR	Kenya	New Caledonia	Sri Lanka
Algeria	Cote d'Ivoire	Kiribati	Nicaragua	Sudan
Angola	Croatia	Korea-DPR	Niger	Suriname
Anguilla	Djibouti	Korea-Republic	Nigeria	Syrian Arab Republic
Argentina	Dominican Republic	Kuwait	Niue	Swaziland
Armenia	Ecuador	Kyrgyzstan	N. Mariana Islands	Tajikistan
Azerbaijan	Egypt	Lao PDR	Pakistan	Tanzania-UR
Bahamas	El Salvador	Latvia	Palau	Thailand
Bahrain	Equatorial Guinea	Lesotho	Panama	Timor-Leste
Bangladesh	Eritrea	Liberia	Papua New Guinea	Togo
Belarus	Estonia	Lithuania	Paraguay	Tokelau
Belize	Ethiopia	Macedonia-TFYR	Peru	Tonga
Benin	Fiji	Madagascar	Philippines	Tunisia
Bhutan	French Polynesia	Malawi	Poland	Turkey
Bolivia	Gabon	Malaysia	Portugal	Turkmenistan
Bosnia & Herzegovina	Gambia	Maldives	Qatar	Tuvalu
Botswana	Georgia	Mali	Romania	Uganda
Brazil	Ghana	Marshall Islands	Russian Federation	Ukraine
Brunei Darussalam	Guam	Mauritania	Rwanda	Uruguay
Bulgaria	Guatemala	Mauritius	St. Vincent &	Uzbekistan
Burkina Faso	Guinea	Mexico	The Grenadines	Vanuatu
Burundi	Guinea-Bissau	Micronesia	Sao Tome & Principe	Venezuela
Cambodia	Guyana	Moldova-Rep.	Saudi Arabia	Viet Nam
Cameroon	Haiti	Mongolia	Senegal	Wallis & Futuna Islands
Cape Verde	Honduras	Montenegro	Seychelles	W. Bank & Gaza Strip
Central African Rep.	India	Morocco	Sierra Leone	Yemen
Chad	Indonesia	Mozambique	Singapore	Zambia
China	Iran	Myanmar	Solomon Islands	Zimbabwe
Colombia	Iraq	Namibia	Somalia	
Comoros	Japan	Nauru	South Africa	
Congo	Kazakhstan	Nepal	Spain	

Source: World Health Organization Global Tuberculosis Control, WHO Report 2006. Countries with Tuberculosis incidence rates of > 20 cases per 100,000 population. For future updates, refer to www.who.int/globalatlas/dataQuery/default.asp

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Grad-Law International Student Health History Form Checklist

☐ Complete Parts 1-4

☐ Submit electronic Waiver if NOT choosing to purchase the student health insurance plan

☐ Have licensed medical provider (MD, PA, or NP) complete Part 5 and sign, or alternative is student can fill out if immunization record available

☐ Sign end of form

☐ Attach a copy of insurance card and be familiar with the coverage

☐ For more information about the immunizations required and Tuberculosis test requirements, visit the Student Health Center website at http://services.pepperdine.edu/healthcenter

☐ Fax to Student Health Center when complete (Fax: 310-506-4588)