

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 conditions may dictate.

X _____ SIGNATURE OF STUDENT
X _____ SIGNATURE OF PARENT
 (Parental endorsement required if student is under 18 yrs of age)

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

All students at Seaver College are required to have a current health insurance policy while attending school. The Electronic Waiver must be submitted at <https://wfis.wellsfargo.com/pepperdine/OnlineWaiver/> 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 <input type="checkbox"/> YES <input type="checkbox"/> 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:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Epilepsy _____ | <input type="checkbox"/> Thyroid Disease _____ |
| <input type="checkbox"/> Kidney Disease _____ | <input type="checkbox"/> Schizophrenia _____ | <input type="checkbox"/> Suicide _____ | <input type="checkbox"/> Tuberculosis _____ |
| <input type="checkbox"/> Blood Disease _____ | <input type="checkbox"/> Migraine Headache _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Eating Disorder _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Severe Depression _____ | <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Other (please explain) _____ |

PART 5: TUBERCULOSIS SCREENING: To be filled out by a licensed MEDICAL PROVIDER (MD, PA, or NP)

PART A:

1. Has the student ever been vaccinated with BCG? Yes No 3. Has the student ever had a positive tuberculosis (TB) screening test? Yes No
 2. Was the student born in any of the countries listed at the end of this form? Yes No Type of screening test _____ Result _____ (mm is PPD) Date: _____

If the answer to ALL of Part A questions is "No," please skip to Part B. If the answer to ANY of the above questions is "Yes," the following is required:

1. An Interferon Gamma Release Assay (IGRA) such as a T-spot or Quantiferon –TB gold test within the past year.
 IGRA test date ___/___/___ Results: Positive Negative
 If IGRA unavailable, patient will be able to obtain upon arrival to 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.
 2. If the IGRA test is negative or unable to be performed, go to Part 6: Immunization Record. If the IGRA test is positive, go to PART C.

PART B:

1. Has the student ever had contact with anyone sick with tuberculosis? Yes No 3. Has the student had significant travel in any of the countries listed at the end of this form? (A stay for at least one week with substantial exposure to the indigenous population). Yes No
 2. 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 Part B questions is "No," please skip to MANDATORY IMMUNIZATIONS. If the answer to ANY of the above questions is "Yes," a PPD or IGRA test (T-spot or Quantiferon-TB gold) is required WITHIN THE PAST YEAR.

Test type: _____ Date ___/___/___ Results _____ (mm if PPD done)

If testing is negative, go to Mandatory Immunizations (section below). If testing is positive, go to Part C.

PART C: This is ONLY for students with positive tests determined above. A chest X-Ray is required WITHIN THE PAST YEAR.

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

PART 6: IMMUNIZATION RECORD: To be filled out and signed by a licensed MEDICAL PROVIDER (MD, PA, or NP)

Tetanus/diphtheria/pertussis(must be Tdap): Primary series and booster within past ten years Date booster given ___/___/___

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

Meningitis Vaccine: Primary injection or booster 16 -12 years of age, OR if over 21 years and living on campus Date received ___/___/___

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

HIGHLY RECOMMENDED IMMUNIZATIONS:

Hepatitis A: Two doses 1st dose ___/___/___ 2nd dose ___/___/___

Varicella: Two doses or history of disease 1st dose ___/___/___ 2nd dose ___/___/___ or Disease ___/___/___

 Name of medical provider

X _____
 Signature of medical provider

X _____
 Signature of Student

 Phone Number of medical provider

Afghanistan	Cook Islands	Iraq	Nicaragua	Sudan
Algeria	Cote d'Ivoire	Japan	Niger	Suriname
Angola	Croatia	Kazakhstan	Nigeria	Swaziland
Argentina	Democratic People's	Kenya	Pakistan	Syrian Arab Republic
Armenia	Republic of Korea	Kiribati	Palau	Tajikistan
Azerbaijan	Democratic Republic	Kuwait	Panama	Thailand
Bahrain	Of the Congo	Kyrgyzstan	Papua New Guinea	Former Yugoslav Republic
Bangladesh	Djibouti	Lao People's	Paraguay	Of Macedonia
Belarus	Dominican Republic	Democratic Republic	Peru	Timor-Leste
Belize	Ecuador	Latvia	Philippines	Togo
Benin	El Salvador	Lesotho	Poland	Tonga
Bhutan	Equatorial Guinea	Liberia	Portugal	Trinidad & Tobago
Bolivia	Eritrea	Libyan Arab Jamahiriya	Qatar	Tunisia
Bosnia & Herzegovina	Estonia	Lithuania	Republic of Korea	Turkey
Botswana	Ethiopia	Madagascar	Republic of Moldova	Turkmenistan
Brazil	French Polynesia	Malawi	Romania	Tuvalu
Brunei Darussalam	Gabon	Malaysia	Russian Federation	Uganda
Bulgaria	Gambia	Maldives	Rwanda	Ukraine
Burkina Faso	Georgia	Mali	St. Vincent and the Grenadines	United Republic of Tanzania
Burundi	Ghana	Marshall Islands	Sao Tome & Principe	Uruguay
Cambodia	Guam	Mauritania	Senegal	Uzbekistan
Cameroon	Guatemala	Micronesia	Serbia	Vanuatu
Cape Verde	Guinea	Mongolia	Seychelles	Venezuela
Central African Republic	Guinea-Bissau	Montenegro	Sierra Leone	Viet Nam
Chad	Guyana	Morocco	Singapore	Yemen
China	Haiti	Mozambique	Solomon Islands	Zambia
Colombia	Honduras	Myanmar	Somalia	Zimbabwe
Comoros	India	Nambibia	South Africa	
Congo	Indonesia	Nepal	Sri Lanka	

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



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
 - 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>
- * **Please note:** In order to reduce the amount of duplicates received by the Student Health Center, please either FAX or MAIL your Health History Form