PEPPERDINE
UNIVERSITY
Student Health Center

UNDERGRADUATE HEALTH HISTORY

THIS FORM IS REQUIRED FOR
REGISTRATION AND ATTENDANCE

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	C.W.I.D.#

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

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

NAME OF PERSONAL PHYSICIAN	CITY/STATE	PHONE NO. ( )

ETHNICITY: ☐ 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 that provides adequate coverage in California. 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 ☐ YES ☐ NO AMOUNT _____	SIGNATURE/ DATE

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

ALLERGIES TO MEDICATIONS, INSECT BITES, FOOD, LATEX, AND ASSOCIATED REACTIONS

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_____	☐ Tuberculosis_____
☐ Blood Disease_____	☐ Migraine Headache_____	☐ Diabetes_____	☐ Eating Disorder_____
☐ Asthma_____	☐ Severe Depression_____	☐ Cancer_____	☐ Other (please explain) _____

NAME: _____ BIRTHDATE (M/D/Y):_____/_____/_____

PART 5: TUBERCULOSIS SCREENING: May be filled out by student OR a licensed medical provider (MD, PA, NP, RN)

1. Has the student ever been vaccinated with BCG? ☐ Yes ☐ No
2. Was the student born in any of the countries listed at the end of this form? ☐ Yes ☐ No
3. Has the student ever had a positive tuberculosis (TB) screening test? ☐ Yes ☐ No
   Type of screening test____ Result_____ (mm if PPD) Date: _____
4. Has the student ever had contact with anyone sick with tuberculosis? ☐ Yes ☐ No
5. Has the student had substantial exposure to a high risk group? (e.g. work or exposure in orphanages, hospitals, prisons, OR travel of more than two weeks in any of the countries listed at the end of this form with substantial exposure to the indigenous population.) ☐ Yes ☐ No

- If the answer to ALL 5 questions is "No," no further testing is required. Go to Part 6: Proof of Immunization.

- If the answer to ANY of the 5 questions is "Yes," further testing and documentation is required as follows:

An Interferon Gamma Release Assay (IGRA) such as a T-spot or Quantiferon –TB gold test is required within the past year.
IGRA Test Date: ___/___/___ Results: ☐ Positive ☐ Negative

*If IGRA testing is unavailable, student will be able to obtain at the Pepperdine Student Health Center.

**If only question # 5 is "Yes" (i.e. questions 1, 2, 3, and 4 were all "No") either an IGRA or PPD is acceptable.
If PPD done: Date: ___/___/___ Results: _____ (mm)

- If testing is positive, a chest x-ray is required WITHIN THE PAST YEAR.
CXR results: ☐ Abnormal ☐ Normal Date Obtained ___/___/___

- **If testing was done (PPD, IGRA and/or CXR) attach documentation or medical provider's signature/stamp below.**

PART 6: PROOF OF IMMUNIZATION: 1. Complete online immunization record. Obtain any needed immunizations.

2. Submit copies (via fax or mail) of official immunization records OR have the following filled out and signed by a licensed medical provider.
Note: A physical exam is *not* required.

MANDATORY IMMUNIZATIONS

Tetanus/diphtheria/pertussis(must be Tdap): Primary series and Tdap 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 given ≥ 16 years of age (may opt out if over 21 and living off campus) Date received___/___/___ Type_____

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 ___/___/___

_____ X_____
Name of medical provider Signature of medical provider + Stamp

X_____ _____
Signature of Student Phone Number of medical provider

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

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