

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: 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 <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 <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 if PPD done)

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 is unavailable, student 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 Part 6: Immunization Record. If the answer to ANY of Part B 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 Part 6: Immunization Record. If testing is positive, go to Part C.

PART C: This is ONLY for students with positive tests determined in Parts A and B 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)

MANDATORY IMMUNIZATIONS

- Tetanus/diphtheria/pertussis:** Primary series and booster within past ten years Date booster given ___/___/___ Type: Tdap Td
Hepatitis B: Three doses required 1st dose ___/___/___ 2nd dose ___/___/___ 3rd dose ___/___/___ or positive titer showing immunity ___/___/___
Meningitis Vaccine: Primary injection or booster between the ages of 16-21 OR any age if 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 Republic of Korea	Kenya	Pakistan	Syrian Arab Republic
Armenia	Democratic Republic of the Congo	Kiribati	Palau	Tajikistan
Azerbaijan	Djibouti	Kuwait	Panama	Thailand
Bahrain	Dominican Republic	Kyrgyzstan	Papua New Guinea	Former Yugoslav Republic of Macedonia
Bangladesh	Ecuador	Lao People's Democratic Republic	Paraguay	Timor-Leste
Belarus	El Salvador	Latvia	Peru	Togo
Belize	Equatorial Guinea	Lesotho	Philippines	Tonga
Benin	Eritrea	Liberia	Poland	Trinidad & Tobago
Bhutan	Estonia	Libyan Arab Jamahiriya	Portugal	Tunisia
Bolivia	Ethiopia	Lithuania	Qatar	Turkey
Bosnia & Herzegovina	French Polynesia	Madagascar	Republic of Korea	Turkmenistan
Botswana	Gabon	Malawi	Republic of Moldova	Tuvalu
Brazil	Gambia	Malaysia	Romania	Uganda
Brunei Darussalam	Georgia	Maldives	Russian Federation	Ukraine
Bulgaria	Ghana	Mali	Rwanda	United Republic of Tanzania
Burkina Faso	Guam	Marshall Islands	St. Vincent and the Grenadines	Uruguay
Burundi	Guatemala	Mauritania	Sao Tome & Principe	Uzbekistan
Cambodia	Guinea	Micronesia	Senegal	Vanuatu
Cameroon	Guinea-Bissau	Mongolia	Serbia	Venezuela
Cape Verde	Guyana	Montenegro	Seychelles	Viet Nam
Central African Republic	Haiti	Morocco	Sierra Leone	Yemen
Chad	Honduras	Mozambique	Singapore	Zambia
China	India	Myanmar	Solomon Islands	Zimbabwe
Colombia	Indonesia	Namibia	Somalia	
Comoros		Nepal	South Africa	
Congo			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