PEPPERDINE
UNIVERSITY
Student Health Center

UNDERGRADUATE HEALTH HISTORY

THIS FORM IS REQUIRED FOR
REGISTRATION AND ATTENDANCE
FAX TO 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: ☐ 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 ☐ 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___________________	☐ Tuberculosis_______________
☐ Blood Disease__________________	☐ Migraine Headache_________	☐ Diabetes__________________	☐ Eating Disorder_____________
☐ Asthma_______________________	☐ Severe Depression_________	☐ Cancer___________________	☐ 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
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 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
2. Does the student have immunosupression due to chronic steroid use, HIV, anti-cancer drugs, or other causes? ☐ 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

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 if over 21 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
Algeria
Angola
Argentina
Armenia
Azerbaijan
Bahrain
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia
Bosnia & Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
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
French Polynesia
Gabon
Gambia
Georgia
Ghana
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Japan
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libyan Arab Jamahiriya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Micronesia
Mongolia
Montenegro
Morocco
Mozambique
Myanmar
Namibia
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
Sri Lanka
Sudan
Suriname
Swaziland
Syrian Arab Republic
Tajikistan
Thailand
Former Yugoslav Republic Of Macedonia
Timor-Leste
Togo
Tonga
Trinidad & Tobago
Tunisia
Turkey
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela
Viet Nam
Yemen
Zambia
Zimbabw

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