CALIFORNIA INSTITUTE OF TECHNOLOGY

STUDENT HEALTH CENTER MAIL CODE 1-8
PASADENA, CALIFORNIA 91125
(626) 395-6393, Fax (626) 585-1522

INSTRUCTIONS AND INFORMATION:

1. The primary purpose of this form is to assure that immunizations are current and that the student poses no public health problems. It also provides a means of identifying students with special health needs and an historical basis for the provision of health care through the Student Health Service.
2. This form must be **returned to the Student Health Center by July 31. All pages must be completed.** (Return the completed form in the envelope provided). **Partially completed form will not be processed.**
3. **Registration will be withheld until these forms are returned with documentation of required immunization and results of all laboratory tests as indicated.**
4. Information on this form is **CONFIDENTIAL** and to be used solely for the Health Services, and will not be released without the student's consent.

PERSONAL HISTORY (To be filled out by applicant)

NAME_____
Last First Middle

HOME ADDRESS_____
Street City, State/Country Zip Code

HOME PHONE NUMBER (Include area code) _____

E-MAIL ADDRESS (if available) _____

SEX: Female_____ Undergraduate_____
Male_____ Graduate_____ Date of Birth _____
Month/day/year

SPECIFY PERSON TO BE NOTIFIED IN CASE OF EMERGENCY:

Name _____ Relationship _____Phone_____

Address_____
Street City, State/Country Zip Code

MEDICAL INSURANCE (For entering undergraduate,, academic year 2012-2013) If you will continue to be covered by your parent's or other medical insurance, please indicate below:

Name of Insurance Plan _____Policy#_____

PARENTS OF STUDENTS UNDER 18 PLEASE COMPLETE THIS SECTION

I the undersigned, parent/legal guardian of _____, a minor, do hereby consent to an x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital service that may be rendered to said minor, under the instructions of the Caltech Medical Staff, whether such diagnosis or treatment is rendered at the office of said physicians or at a hospital licensed by the state of California

_____ _____
Signature of Parent/Legal Guardian Date

Name: _____

FAMILY MEDICAL HISTORY: Please indicate all biological family members who have experienced any of the following conditions. If deceased, age at time of death. (i.e., Asthma, paternal grandfather, 96).

Biological family member if deceased, age

Asthma _____
Cancer, (type) _____
High Blood Pressure _____
Diabetes _____
Heart Disease _____
High Cholesterol _____
Thyroid Condition _____
Tuberculosis _____
Alcoholism _____
Other serious chronic disease (specify) _____

PERSONAL MEDICAL HISTORY:

Any allergies (medication) _____ (food) _____ (others) _____

Tobacco Use ___ Yes ___ No ___ Pack a day ___ Years ___ I quit _____ ago
_____ other tobacco products (specify) _____

Alcohol Use ____Yes ____No How Often_____ Quantity/Amount _____

List any surgery, hospitalizations (including psychiatric), illnesses, or significant injuries and approximate dates: _____
_____

List any medications you are taking (including birth control pills/non-prescription pills):
_____
_____

Please describe any ongoing medical problem? _____
_____

For women only: most recent pap and pelvic exam if any (date and result): _____
_____

_____ _____
Student's Signature **Date**

Name:_____

PHYSICAL EXAMINATION

(Within one year prior to registration)

All Information Is Required. Form Must Be Completed By A Health Care Provider

Height _____ Weight _____ BP _____ Pulse _____
Skin: _____
Head: _____
Eyes: _____ Snellen R/20 _____ L/20 _____
Corrected R/20 _____ L/20 _____
Contact lens/glasses _____
Ears:_____
Nose: _____
Mouth and Throat: _____
Neck:_____
Thorax: _____ Lungs: _____
Breast: _____
Spine/Back: _____
Heart: _____
Abdomen: _____
Genito-urinary (if indicated) _____
Extremities: _____
Lymph Nodes: _____
Reflexes: _____

Laboratory exam: Hematocrit:_____% urine sugar _____ urine protein _____

Does this student have a medical condition for which ongoing health care is required?
_____
_____

May this student participate in athletic activities? Any restrictions or contraindications?
_____

Recommendations for health care at Caltech? _____
_____

_____ _____
Signature of Health Care Provider **Date of Exam**

Health Care Provider's Name _____
Address _____
Tel. No._____
Fax No. _____

IMMUNIZATION RECORD

Name: _____ Birth Date: _____
Last first

Address: _____

To be **completed** and **signed** by your health care provider. ***All information must be in English.***

A. MMR (Measles, Mumps, Rubella) REQUIRED
(Two doses required)

1. Dose 1 given at age 12 months or later #1_____
mo/day/year
2. Dose 2 given at least 28 days after first dose #2 _____
mo/day/year

OR

3. Report of positive immunity (**attach copy of report)** Immune _____ Not Immune _____

B. Tetanus-Diphtheria-Pertussis REQUIRED
Primary series of four with DTaP or DTP _____
year completed

Booster: within the last 10 years : Tdap preferred _____ Td _____
mo/day/year *mo/day/year*

C. Hepatitis B REQUIRED (First 2 doses received prior to arrival at Caltech, third dose can be completed at Caltech)

Dose # 1 _____ Dose# 2 _____ Dose # 3 _____ **OR**
mo/day/year *mo/day/year* *mo/day/year*

Hepatitis B surface antibody (**attach copy of report**) Reactive _____ Non-reactive _____

D. Meningococcal vaccine REQUIRED one dose *(no more than 5 years ago if Menactra or Menveo and no more than 3 years ago for Menomune)* for freshmen undergraduate students, persons with terminal deficiencies or asplenia. Non-freshmen college students under 25 years of age may choose to be vaccinated to reduce their risk of meningococcal disease

Date _____ Menomune _____ Menactra _____
mo/day/year

E. Hepatitis A (strongly recommended) 2 doses at least 6-12 months apart (First dose prior to arrival at Caltech. Second dose can be completed at Caltech)

Dose# 1 _____ Dose #2 _____
mo/day/year *mo/day/year*

F. Polio (recommended) Primary series should be complete_____ Booster if any _____
year completed *mo/day/year*

G. Varicella (recommended) a positive varicella antibody, or two doses of vaccine meets the requirement

Dose # 1 _____ Dose # 2, _____ (given at least 12 weeks after the first dose ages 1-12 years and at least 4 weeks weeks after the first dose if age 13 years or older)

OR

Varicella antibody (**attach copy of report**) reactive_____ non-reactive _____

H. Human Papillovirus Vaccine (optional) three doses of vaccine for female or male college students 11 - 26 years

Dose # 1 _____ Dose #2 _____ Dose # 3 (if HPV 4) _____

Health Care Provider _____ Date signed_____

Address_____Tel. No._____

Tuberculosis (TB) Screening/Testing Form (Required)

Student Name _____ Date of birth _____
LAST FIRST MIDDLE MONTH/DAY/YEAR

1. Country of birth: _____
2. To the best of your knowledge, have you had close contact with anyone who was sick with tuberculosis? ☐ Yes ☐ No
3. Were you born in one of the countries or territories on the list below? ☐ Yes ☐ No
4. Have you traveled or lived for more than one month in any of these countries or territories? ☐ Yes ☐ No

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

If you answered YES to any of the above screening questions, *you are required to submit a Mantoux 5TU PPD test date and or a copy of an Interferon Gamma Release Assay (IGRA) Quantiferon-TB Gold or TSPOT test*

- The test must have been performed within six months prior to your CIT registration date.
- Multiple-puncture TB tests are not acceptable (tine, HEAF, etc.).
- History of BCG is not a contraindication to TB testing.

If you answered NO to all of the above questions, *no further testing or further action* is required.

Mantoux 5TU test date: _____
MONTH/DAY/YEAR
Result: _____mm

OR

(IGRA) Circle the specific method: QFT-G TSPOT
Test date: _____
MONTH/DAY/YEAR
Result: _____ **(include copy)**

If you have ever had tuberculosis or had a positive Mantoux PPD or Interferon Gamma Release Assay (IGRA) Quantiferon-TB Gold or TSPOT, your health care provider must do the following:

1. Attach a copy of a report for a chest X-ray that was taken on or after the positive result. This chest X-ray report must be written in English and dated within six months prior to entrance to CIT. (Do not send x-ray film)
2. Provide information about therapy. Start date: _____ Completion date: _____
   MONTH/DAY/YEAR MONTH/DAY/YEAR
3. Declination of therapy? ☐ Yes ☐ No
4. Provide a clinical evaluation. Does the patient exhibit cough, hemoptysis, fever, chills, night sweats or weight loss?
   ☐ Yes ☐ No If yes, please describe: _____

Signature of physician, physician assistant, nurse practitioner, or registered nurse (*parents or other relatives of the student are not acceptable as providers of care).*

_____ _____ Date _____
SIGNATURE OF PHYSICAN/PA/NP/RN PRINTED NAME MONTH/DAY/YEAR

ADDENDUM

NAME_____

Have you ever experienced or are now experiencing any of the following (please check all that apply)?

Have you experienced or are now experiencing any of the following?		**Have you Received** Treatment?		**Did Your treatment include** (Please check all that apply)			**Dates of** Treatment
	Yes **No**	**Yes**	**No**	**Counseling**	**Meds**	**(list Medication)**	
Anxiety	☐ ☐	☐	☐	☐	☐	_____	_____
Depression	☐ ☐	☐	☐	☐	☐	_____	_____
Eating Disorder:				☐	☐	_____	_____
Anorexia	☐ ☐	☐	☐				
Bulimia	☐ ☐	☐	☐	☐	☐	_____	_____
Both	☐ ☐	☐	☐	☐	☐	_____	_____
Obsessive Compulsive				☐	☐	_____	
Disorder	☐ ☐	☐	☐	☐	☐	_____	_____
Panic Disorder	☐ ☐	☐	☐	☐	☐	_____	_____
Phobia	☐ ☐	☐	☐				_____

Do you plan to (circle one) continue, resume or begin receiving help for these problems while at Caltech

☐ Yes ☐ No

Comments: _____

_____

_____

_____

California Institute of Technology
Archibald Young Health Center

MENINGITIS IMMUNIZATION ADVISORY AND NOTIFICATION

Dear Student/Parent,

As the Medical Director of the Caltech Student Health Center, I am writing to inform you that legislation has been enacted in California (California Law AB 1452) requiring all new post secondary students receive the meningitis vaccine or sign a waiver after reading information about the risks of meningitis.

What is meningococcal (meningitis) disease? Meningitis is rare, but when it strikes, this potentially fatal bacterial disease can lead to swelling of fluid surrounding the brain and spinal column and in some cases death. Symptoms range from flu like symptoms to permanent disabilities. Early diagnosis and treatment can prevent the most severe effects of meningitis, but the rapid progress of the illness and the similarity of its symptoms to the common flu often results in delayed treatment.

How is the disease spread? Meningococcal meningitis is spread through the air via respiratory secretions or close contact with an infected person. This can include coughing, sneezing, kissing or sharing items such as utensils, cigarettes and drinking glasses.

Who is at most risk for getting meningococcal disease? People who live in settings such as college dormitories are at risk, as are military recruits who live in close quarters, as well as people who travel to certain parts of the world where the disease is very common. Children and adults with damaged or removed spleens are also at risk.

Are some students in college and post secondary schools at risks for meningococcal disease? College freshmen living in residence halls or dormitories are at an increased risk for meningococcal disease as compared to individuals of the same age not attending college. The setting, combined with risk behaviors such as alcohol consumption, exposure to cigarette smoke, sharing food or beverages, and activities involving exchange of saliva, may be what puts college students at a greater risk for infection.

The risks for meningococcal disease for other college students, in particular older students and students who do not live in congregate housing, is not increased. However, meningococcal vaccine is a safe and efficacious way to reduce their risk of contracting this disease.

Is there a vaccine against meningococcal disease? Yes, there are currently 2 vaccines (Menomune – a polysaccharide vaccine and Menactra – a conjugate vaccine) available. Both of these vaccines provide protection against 4 of the serogroups of the bacteria, called groups A, C, Y and W 135. These 4 serogroups account for approximately two-thirds of the cases that occur in the U.S. each year. There is currently no vaccine for

serogroup B which accounts for one-third of the cases. Protection from immunization with the meningococcal polysaccharide vaccine is not life-long; it last about 3 to 5 years. The meningococcal conjugate vaccine is expected to help decrease disease transmission and provide more long-term protection.

Is the vaccine safe? The meningococcal vaccine has an excellent safety profile. However, like any medicine, is capable of causing serious problems such as severe allergic reactions. Some people who get the vaccine have mild side effects such as redness or pain where the shot was given. These symptoms usually last for 1 – 2 days. A small percentage of people who receive the vaccine develop a fever. Immunization is deferred during any acute illness and the vaccine is not given to pregnant women.

Where can a student get vaccinated? Students and their parents should contact their healthcare provider and make an appointment to discuss meningococcal disease, the benefits and risk of vaccination, and the availability of these vaccines.

Where can I get more information? More information about the disease and vaccine can be found at the following.

Centers of Disease Control and Prevention (CDC)
www.cdc.gov

American College health Association (ACHA)
www.acha.org

Meningitis Foundation of America
www.musa.org

California Institute of Technology Vaccine Requirement. The Student Health Center requires all freshmen students receive meningitis vaccine or sign a waiver. Menactra is preferred but Menomune is acceptable if given within the past 3 years. Please have the meningitis immunization completed before arrival. If you have any questions contact 626-395-6393.

Sincerely.

Stuart C. Miller, M.D.
Medical Director
Caltech Health Center

CALIFORNIA INSTITUTE OF TECHNOLOGY
ARCHIBALD YOUNG HEALTH CENTER

MENINGITIS LETTER ACKNOWLEDGEMENT FORM
(Complete, Sign, and Return with Health Form)

I have read the letter on meningitis and flu vaccination clinic and:

□ I intend to receive the meningococcal vaccine at:

□ My doctor's office

□ Caltech Student Health Center

□ I do not intend to receive the vaccine

□ I have already received the vaccine

_____ _____
Name (Print) Date

_____
Signature

Note: This release form is for the meningitis vaccination only.

01/06