



Entrance Health Forms

Student Health Services
757 College Way
Claremont, CA 91711
P: (909) 621-8222 – Fax: (909) 621-8472

Congratulations and welcome to The Claremont Colleges (TCC) and your Student Health Services! Attached is your **Entrance Personal Health History/Medical Examination Report Form**. This form provides your history of previous medical care from your personal health care provider and is the basis for your continuing medical care on campus. ***Completion in full regardless of your status (i.e. part-time, exchange, or transfer student) is required for registration at any of The Claremont Colleges.***

This form must be submitted by July 15th for students beginning in the Fall semester and by January 15th for students beginning in the Spring semester.

Please complete pages one, two, and three yourself. Pages four, five, and six are to be completed by your personal health care provider. Please note that ***required*** immunizations and screening include:

- ☐ COVID – up-to-date on series
- ☐ Influenza vaccine – must complete vaccine no later than October 31st of entering school year.
- ☐ Hepatitis B (HBV) - 3 dose series
- ☐ Measles, Mumps, and Rubella (MMR) - two dose series
- ☐ Meningococcal Conjugate (MCV4) and booster dose at or after age 16
- ☐ Primary series of Tetanus, Diphtheria, Pertussis and Tdap booster within the last 10 years
- ☐ Tuberculosis screening questionnaire (TB skin test, CXR, or QuantiFERON blood test to be performed, if indicated)
- ☐ Varicella Zoster (VZV) - 2 dose series or date of disease

Immunization records are required to prevent outbreaks of disease on campus as well as to help recognize students who are at risk should a disease outbreak occur. **If you cannot locate your immunization records, you have two options:**

- ☐ You can be re-immunized.
- ☐ You can have a blood test to determine immunity for HBV, MMR, and VZV. If the blood test indicates you are not immune to HBV, MMR, or VZV you will have to be re-immunized.

Student Health Services participates in the California Immunization Registry (CAIR). More information can be found at https://cairweb.org/docs/CAIR_Disclosure_Eng.pdf.

Once your form has been completed, mail it directly to Student Health Services at 757 College Way, Claremont, CA 91711, fax it to (909) 621-8472 or upload it directly to SHS at <https://bit.ly/2WfxT3m>.

All students are required to carry major medical insurance to provide supplemental coverage in the event of an acute injury or illness requiring hospitalization. A Student Health Insurance Plan (SHIP) is available to students attending TCC. International students are required to purchase the Student Health Insurance Plan (SHIP). Please contact your Dean of Students' Office for brochures and plan information.

The staff at Student Health Services looks forward to assisting you with your health care needs while you are at The Claremont Colleges. Our website, www.services.claremont.edu/student-health-services has more information about our services.

Thank you for your cooperation. Your compliance helps protect the health of the entire campus community.



MENINGOCOCCAL DISEASE

This information is to inform you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis, and the current recommendations from the Centers for Disease Control and Prevention (CDC) along with the recommendations of the Advisory Committee on Immunization Practices (ACIP).

Meningitis is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. If not treated early, meningitis can lead to swelling of the fluid surrounding the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation, and even death. The disease strikes about 4000 Americans each year and claims about 500 lives. Between 100 and 125 meningitis cases occur on college campuses nationwide and as many as 15 students will die from the disease.

The Claremont Colleges, in an effort to keep the campus safe and as healthy as possible, now require all incoming freshmen to show proof of meningococcal vaccination. The vaccine is available at Student Health Services any day by appointment. For more information, please feel free to contact our health service and/or consult your health care provider. You can also find information about this disease on our web site, www.services.claremont.edu/shs/, which links to the website for the Centers for Disease Control and Prevention (CDC), <http://www.cdc.gov/> and the American College Health Association website, <http://www.acha.org/meningitis>.

Please note that the required Meningococcal Tetravalent (Men ACWY) vaccination is different from the recommended Meningococcal B vaccination. All students need to have had a Meningococcal Tetravalent vaccination, with a booster dose given at age 16 or older. Meningococcal B vaccinations are strongly recommended for all students but are not required at this time.

Please select your campus:

☐ Harvey Mudd College

Please indicate your academic status

☐ First-Year Freshman

☐ Sophomore

☐ Junior

☐ Senior

To provide a safe and healthy environment at The Claremont Colleges, **ALL** students are required to complete this health record **PRIOR** to entry. This form **MUST** be returned by **July 15th for the Fall semester or January 15th for the Spring semester.**

IMPORTANT GENERAL INFORMATION

- Please read prior to completing this form:
 - SHS letter of introduction
 - Information on meningococcal disease
- If documentation of immunization is unavailable, you must be re-immunized for Hepatitis B, Measles, Mumps, Rubella, and Varicella Zoster or show proof of immunity for that disease. Meningococcal vaccination at or after age 16 and a Tdap booster within the last 10 years are required. COVID-19 vaccination is required to be up-to date. Annual influenza vaccination is required by October 31st.
- Please make a copy of this form for your records.

Part I: PATIENT INFORMATION (to be completed by student OR guardian if under age 18)

Full Legal Name

First: _____ Middle Initial: _____ Last: _____ Date of Birth: _____

Name Chosen: _____ Pronouns: _____ Gender: _____

Campus ID#: _____ Home Address: _____

City: _____ State: _____ Zip Code: _____ Country: _____

Student Cell: (____) _____ Campus Email: _____@_____.edu

Emergency Contact:

Name: _____ Relationship to Student: _____ Primary Phone Number (____) _____

Address: _____
Street Number City State Zip Code Country

MEDICAL CARE AUTHORIZATION

I, the undersigned, hereby specifically authorize The Claremont Colleges Services Student Health Services health care provider or whomever they may designate to administer any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, in serious or major illnesses or injuries without prior notification of the undersigned or any other person and without obtaining consent of the undersigned or any other person, if in the judgment of the physician or designee it is necessary for health care reasons to proceed with the treatment without delay. I further agree that the attending health care provider or whomever they may designate may evaluate and treat all other injuries or illnesses for which help is sought. In the case of a minor student, (under the age of 18), this treatment may proceed without prior notification of the undersigned parent or guardian. I further agree that the Student Health Services may release any medical information to other campus health care providers at Monsour Counseling and Psychological Services who may be providing care.

SIGNATURE OF STUDENT: All students must sign. If under 18 years of age, Parental Signature is also required.

STUDENT SIGNATURE: _____ Date: _____

PARENT/GUARDIAN SIGNATURE: _____ Date: _____

NOTE: A **release of information (ROI)** must be signed, dated, and on file for all students, regardless of age, before any patient records and/or billing information may be released/discussed with a parent, guardian, spouse, or healthcare provider. A form is available at <https://services.claremont.edu/wp-content/uploads/2021/09/ROI-092821.pdf> or at Student Health Services

****All forms should be uploaded to directly to SHS at <https://bit.ly/2WfxT3m> or may be submitted by mail to Student Health Services at 757 College Way, Claremont, CA 91711 or by fax to (909) 621-8472.**



Patient Name: _____

PART II: PERSONAL HEALTH HISTORY: TO BE COMPLETED BY STUDENT

Have you ever been diagnosed with any of the following?

- | Yes | Yes | Yes |
|---|---|--|
| <input type="checkbox"/> Acne, severe | <input type="checkbox"/> Genital warts (HPV) | <input type="checkbox"/> Self Injury |
| <input type="checkbox"/> Alcohol/drug addiction | <input type="checkbox"/> Headaches, frequent, severe | <input type="checkbox"/> Thyroid condition |
| <input type="checkbox"/> Allergies of any kind | <input type="checkbox"/> Head injury | <input type="checkbox"/> Urinary tract infection (recurrent) |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hearing difficulty | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Anxiety or panic attacks | <input type="checkbox"/> Heart disease | _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart murmur/Arrhythmia | |
| <input type="checkbox"/> Asthma, including exercise induced | <input type="checkbox"/> Hepatitis | |
| <input type="checkbox"/> Attention deficit disorder/ADHD | <input type="checkbox"/> High blood pressure | |
| <input type="checkbox"/> Back pain, chronic | <input type="checkbox"/> Immune system problem | |
| <input type="checkbox"/> Bipolar disorder | <input type="checkbox"/> Kidney disease | |
| <input type="checkbox"/> Blood clotting disorder | <input type="checkbox"/> Leukemia | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Loss of a paired organ (eye, kidney, testicle) | |
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Meningitis/Encephalitis | |
| <input type="checkbox"/> COVID-19 | <input type="checkbox"/> Menstrual problems | |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Mononucleosis | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Ovarian cyst | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pneumonia | |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Positive tuberculin skin test | |
| <input type="checkbox"/> Ear, nose, or throat disorders | <input type="checkbox"/> Psychiatric treatment | |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Sickle cell trait/disease | |
| <input type="checkbox"/> Fainting/Blackouts | | |
| <input type="checkbox"/> Genital herpes | | |

Do you have a family history of any of the following conditions? (parents, grandparents, or siblings)

- | |
|--|
| <input type="checkbox"/> Blood clotting disorder |
| <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Sudden death |
| <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Other: _____ |
| _____ |
| _____ |

If you answered "YES" to any of the conditions listed above, please explain in the space below. Give the DATE and OUTCOME of ALL conditions above or any other conditions or medical history not listed. You may attach additional sheets and old medical records if necessary.

List all other surgical procedures, except fractures, with dates: _____

List all medical/psychiatric hospitalizations, with dates: _____

List all significant injuries and illnesses, with dates: _____

List any medications taken regularly OR attach a list to this packet: _____

List Allergy/Medication Reaction History: _____



Patient Name: _____

PART III: MEDICAL INSURANCE

It is required that all students be covered by medical insurance to provide supplemental coverage for medical costs in the event of a severe illness, injury, or accident. **The Claremont Colleges Services: Student Health Services DOES NOT do any medical insurance billing.** However, information about a student's medical coverage can expedite the process of community subspecialty referrals if necessary as well as insurance identification card carried by the student.

Students of The Claremont Colleges are automatically enrolled into SHIP (Student Health Insurance Plan). Students wishing to waive SHIP coverage **MUST** submit proof of coverage prior to registration via their campus online waiver portal.

Please note that this form is ONLY for Student Health Service's use and DOES NOT waive you from SHIP. If you are not waiving SHIP coverage, please check the box below. SHIP policy information will become available after the start of the semester.

☐ I am enrolling into SHIP.

☐ I have my own insurance and will waive SHIP. Current medical insurance information is completed below.

Name of Insurance Carrier: _____

Policy Number(s): _____ Phone Number for Reporting Claims: (_____) _____



Patient Name: _____

Part IV: PHYSICAL EXAMINATION: TO BE COMPLETED BY A HEALTH CARE PROVIDER ONLY

Forms completed by family member/relative will NOT be accepted.

TO THE HEALTH CARE PROVIDER: Please review the health history provided by the student and add or complete anything of significance. After a complete physical examination, we would appreciate your evaluation of the student's physical status, both for the student and as a basis for their continuing medical care. Copy of physical completed in the last twelve months is accepted. Please check the appropriate box below.

☐ Physical completed in the last 12 months attached. Complete Section B with signature or stamp at bottom of page.

☐ Physical completed below. Signature or stamp REQUIRED at bottom of page.

Section A:

Height: _____ Weight: _____ Pulse: _____ Blood Pressure: _____

Vision (Uncorrected): R 20/ _____ L 20/ _____ (Corrected): R 20/ _____ L 20/ _____

List ANY allergies to medications or foods: _____

PHYSICAL EXAM	NORMAL	ABNORMAL	EXPLANATION OF ABNORMAL FINDINGS
Head/EENT			
Neck/Lymph/Thyroid			
Cardiovascular			
Respiratory			
Breast exam			
Abdomen			
Hernia/Testicles			
Musculo-skeletal			
Neurologic			
Skin			

Section B:

List all medications you are prescribing for the patient: _____

Please describe ANY current treatment and recommended further treatment: _____

Recommendations for intramural/intercollegiate physical activity:

☐ May participate in sports without restrictions

☐ Should not participate in sports (please explain): _____

☐ May participate with the following restrictions: _____

☐ Medical or orthopedic problem must be evaluated before participation is allowed (please explain): _____

PART IV: HEALTH CARE PROVIDER SIGNATURE (MD, DO, NP, PA)

Provider Signature: _____ Date: _____

Please stamp here if using stamp



Patient Name: _____

PART V: TB SCREENING: TO BE COMPLETED BY THE HEALTH CARE PROVIDER.

TUBERCULOSIS SCREENING (REQUIRED)

1. Does the patient have a history of a positive tuberculin skin test (PPD) in the past? ☐ Yes ☐ No
 - If no, proceed to #2
 - If yes, include date of positive PPD, mm induration, date and results of most recent chest x-ray and documentation of any treatment received for latent tuberculosis.
 - Skin test SHOULD NOT be repeated. Proceed to #2
2. Does the student have signs or symptoms of active tuberculosis disease? ☐ Yes ☐ No
 - If no, proceed to #3
 - If yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated
3. Is the student a member of a high-risk group? ☐ Yes ☐ No

***High-risk groups include the following:**

- Students who were born in or resided in countries where TB is endemic.
 - As it is easier to identify countries of low rather than high TB prevalence, students should undergo TB screening if they were born in or resided in countries **EXCEPT**:
 - Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia, USA, Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand
- Students with HIV infection.
- Students who inject drugs.
- Students who have resided in or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters.
- Students with clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunoileal bypass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g., prednisone \geq 1 month) or other immunosuppressive disorders.

***If you answered NO to questions 1-3, please skip the following section and sign at the bottom of the page.**

***If you answered YES to questions 1-3, please continue:**

- Place tuberculin skin test [Mantoux only: Inject 0.1 ml of purified protein derivative (PPD) tuberculin containing 5 tuberculin units (TU) intradermally into the volar (inner) surface of the forearm]. A history of BCG vaccination should not preclude testing of a member of a high-risk group.
- **Tuberculin Skin Test: (Must be performed within 6 months of arrival on campus)**

Date Placed: _____ Date Read: _____
Result: _____ (Record actual mm of induration, transverse diameter; if no induration, write "0". Interpretation (Based on mm induration as well as risk factors.):

☐ Positive ☐ Negative

Or Interferon Gamma Release Assay (IGRA): Date Obtained: _____ (Specify Method) ☐ QFT-G ☐ QFT-GIT ☐ Other
Result: ☐ Positive ☐ Negative ☐ Intermediate

Chest x-ray result (Required only if tuberculin skin test in #3 or IGRA is positive): Date of CXR: _____ ☐ Normal ☐ Abnormal

PART V: HEALTH CARE PROVIDER SIGNATURE (MD, DO, NP, PA)

Provider Signature: _____ Date: _____

Please stamp here if using stamp



Patient Name: _____

PART VI: IMMUNIZATION RECORD: TO BE COMPLETED BY THE HEALTH CARE PROVIDER

REQUIRED IMMUNIZATIONS

Please check appropriate box → ☐ Copy Attached **OR** ☐ Completed Below

☐ **COVID 19 – (Series Up to Date) ** (Bivalent Booster dose must be on/after September 2022)**

1. Brand: _____ Date Received: _____
2. Brand: _____ Date Received: _____
3. Brand: _____ Date Received: _____
4. Brand: _____ Date Received: _____

☐ **Influenza (due no later than October 31st of entering school year)**

1. _____ (Date Received)

☐ **Tetanus, Diphtheria, Pertussis (#1-DPT, #2-Dtap, #3-DT, #4-Td, #5-Tdap)**

1. _____ (Date Received) / 2. _____ (Date Received) / 3. _____ (Date Received) / 4. _____ (Date Received)
5. **Tdap booster within last 10 years:** _____ (Date Received)

☐ **Meningococcal Tetravalent ACYW-135 (e.g. Menactra, Menveo, Menomune)**

1. _____ (Date Received Tetravalent Conjugate or Polysaccharide / Before Age 16)
2. _____ (Date Received **Booster dose ON/AFTER age 16**)

☐ **Measles, Mumps, Rubella (2 doses) (MMR)**

1. _____ (Date Received) / 2. _____ (Date Received)

☐ Immunity Verified by IMMUNE titer (MUST INCLUDE LAB REPORT)

☐ **Varicella (2 doses) (AKA Chickenpox)**

1. _____ (Date Received) / 2. _____ (Date Received) **OR** Date of Disease: _____

☐ Immunity Verified by IMMUNE titer (MUST INCLUDE LAB REPORT)

☐ **Hepatitis B (3 doses)** Please indicate brand IF patient was given a 2-dose series.

1. _____ (Date Received) / 2. _____ (Date Received) / 3. _____ (Date Received) / Brand if 2 dose series: _____

☐ Immunity Verified by IMMUNE titer (MUST INCLUDE LAB REPORT)

Recommended Immunizations

☐ Meningococcal B

- ☐ Bexsero #1 _____ #2 _____ OR
- ☐ Trumemba #1 _____ #2 _____ #3 _____

☐ Polio #1 _____ #2 _____ #3 _____ #4 _____ Last Booster: _____

☐ Hepatitis A #1 _____ #2 _____

☐ Human Papillomavirus (2, 4, or 9 valent) #1 _____ #2 _____ #3 _____

☐ Pneumococcal Polysaccharide vaccine #1 _____

Prior Travel Immunizations

☐ Typhoid (CIRCLE: Oral / Intramuscular) #1 _____ (Date Received)

☐ Yellow Fever #1 _____ (Date Received)

PART VI: HEALTH CARE PROVIDER SIGNATURE (MD, DO, NP, PA)

Health Care Provider's Name (please print): _____ Title: _____

Address: _____

Street

City

State

Zip Code

Country

Phone Number: (____) _____ Fax Number: (____) _____

Signature: _____ Date: _____

Please stamp here if using stamp



Monsour Counseling & Psychological Services would like to welcome you to our campus! This is an exciting time in your life. To provide optimum mental health services for all our students, we invite you to complete this optional brief survey.

Information provided in this survey is kept confidential and access to any and all information is strictly limited to healthcare professionals at Student Health Services and Monsour Counseling & Psychological Services.

Name: _____ College: _____ Student ID: _____

Have you experienced, or are you now experiencing, any of the following?
(Please check **ALL** that apply).

			Have Received Treatment		Treatment Included: Counseling MEDS	
	YES	NO	YES	NO	YES	NO
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug or Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Mental Health Concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you been hospitalized for the above condition(s)? YES ☐ NO ☐

Do you plan to continue or to begin receiving treatment? YES ☐ NO ☐

☐ MCAPS (on campus)

☐ Other Mental Health Profession (off campus)

If you would like to be contacted by a staff member at MCAPS after the fall semester beings, please indicate your preferred contact information below (cell phone or email):

Please note: Only give your contact information if you wish a staff member at MCAPS to contact you. Also please remember the security of the email cannot be guaranteed, and as such it is NOT a confidential mode of communication.

PLEASE RETURN COMPLETED FORM TO:

Student Health Services
757 College Way
Claremont, CA 91711
Fax (909) 621-8472