Student Health History

Student Affairs

2500 E. Nutwood Ave.
Fullerton, CA 92831 USA
(714) 879-3901 x2311
FAX (714) 681-7224
Email: health@hiu.edu

Last Name: _____ First Name: _____ Student ID#: _____

1. REQUIRED IMMUNIZATION RECORD

HIU students are **required** to obtain the following vaccines and undergo screening/risk assessment for Tuberculosis:

PLEASE SUPPLY DATES OF IMMUNIZATIONS. ALL STUDENTS MUST ATTACH A COPY OF IMMUNIZATION RECORDS TO THIS FORM.
Measles, Mumps and Rubeola (*MMR*) Dose 1: _____ Dose 2: _____ *Two (2) doses with first dose on or after 1st birthday; OR positive titer (laboratory evidence of immunity to disease).*
Varicella (*Chickenpox*) Dose 1: _____ Dose 2: _____ *Two (2) doses with first dose on or after 1st birthday; OR positive titer. History of contracting the disease does not meet compliance.*
Tetanus, Diphtheria, and Pertussis (*Tdap*) Dose: _____ *One (1) dose after age 7.*
Meningococcal Conjugate (*Serogroups A, C, Y, & W-135*) Dose: _____ *One (1) dose on or after age 16 for all students and age 21 or younger.*
Hepatitis B (*Hep B*) Dose: _____ *One (1) dose. Students age 18 and younger (CA Health & Safety Code, Sec. 120390.5)*
Screening/Risk Assessment: Tuberculosis (TB) *All incoming students must complete a Tuberculosis risk questionnaire. Incoming students who are at higher risk* for TB infection, as indicated by answering "yes" to any of the screening questions, should undergo either skin of book testing for TB infection within 1 year of HIU entry.* **Higher risk include travel to or living in South and Central America, Africa, Asia, Eastern Europe, and the Middle East; prior positive TB test; or exposure to someone with active TB disease.* I certify that _____ completed the TB risk questionnaire and does not need to undergo any further testing. *student's name* Clinician Signature: _____ **If answered "yes" please provide the following:** Mantoux Tuberculosis Test (*within the past year*) Date Applied: _____ Date Read: _____ Results: _____ If POSITIVE, must have chest x-ray within 2 years. Date of CXR: _____ Results: _____

2. VERIFICATION BY CLINICIAN OF PAST INFECTION *(CLINICIAN-PLEASE INDICATE MONTH AND YEAR)*

Measles	Mumps	Rubella	Hepatitis B	
_____	_____	_____	_____	Clinician Signature _____

3. BLOOD TEST In lieu of vaccinations, you may provide proof of immunity by checking the appropriate box(es) and ***attaching lab results to this form.***

Serologic confirmation (*blood titer*) of immunity **attached**: ❑ Measles ❑ Mumps ❑ Rubella ❑ Hepatitis B

4. STRONGLY ENCOURAGED IMMUNIZATION RECORD

HIU students are **strongly encouraged** to obtain the following immunizations (*please discuss with your provider*):

PLEASE SUPPLY DATES OF IMMUNIZATIONS IF APPLICABLE	
Hepatitis A (*Hep A*)	*All students regardless of age.*
Human Papillomavirus (*HPV*)	*For woman and men through age 26.*
Influenza (*Flu*)	*Annually; All students regardless of age.*
Meningococcal B (*Meningitis*)	*Students age 16-23 who elect vaccination after discussion with their healthcare provided.*
Pneumococcal	*For students with certain medical conditions (e.g., severe asthma, diabetes, chronic liver or kidney disease).*
Poliovirus (*Polio*)	*Regardless of age, if the series was not completed as a child.*
Immunizations for international travel	*Based on destination.*

5. MEDICAL EXEMPTION ***(Physician/Clinician please check appropriate box)***

I certify that the medical circumstances of the above-named student contraindicate immunization against:

MMR ❑ Hep B ❑

_____ _____

Physician/Clinician Signature *Date* Clinic Stamp if Applicable

6. OTHER EXEMPTION ***(Religious or personal exemption must be reviewed with student affairs personnel by appointment only.)***

a) I request a personal/religious exemption from vaccinations for the following reason:

_____

_____ _____ _____

Student Signature: *Date:* *Director Signature:*

OR

b) I certify that I was born prior to January 1, 1957, and attended primary and secondary school in the United States, will not reside in a campus residence hall (dorm) and will not work with pre-school age children or health care patients as part of my college experience.

Student Signature: _____ Date: _____

I understand that exemption for any of the reasons listed above subjects me to exclusion from campus in the event of an outbreak of a disease for which immunization is required.

Mail or FAX your completed forms and documentation to:

Hope International University • *Student Affairs*
2500 E. Nutwood Avenue • Fullerton, CA 92831 • FAX: (714) 681-7224
***Or email your completed forms and documentation to:* health@hiu.edu**

Student Health Insurance Requirements

Student Affairs

2500 E. Nutwood Ave.
Fullerton, CA 92831 USA
(714) 879-3901 x2311
FAX (714) 681-7224
Email: health@hiu.edu

First Name: _____ Last Name: _____

Student ID: _____

❑ YES My personal health insurance covers illness, injury, and prescription services; AND emergency and non-emergency services in the Orange County California area or area of program.

❑ YES My personal health insurance will be effective on or before the first day of the semester. It meets the substantial compliance standards outlined in the Student Handbook.

❑ YES I understand that I must maintain active and continuous compliant health insurance to be enrolled as a traditional undergraduate student and that noncompliance will result in not being able to attend classes or participate in athletic events.

❑ YES I also acknowledge that if I drop, lose or change insurance during the academic year I must notify the Student Affairs Office within 30 days to provide new policy information.

REQUIRED INSURANCE INFORMATION—*Please include all prefix letters and numbers for policy information.*

Insurance Company Name: _____

Insurance Company Customer Service Phone Number: _____

Insurance Policy/Individual/Subscriber Number: _____

Insurance Group or Employer Number (*if applicable*): _____

POLICY HOLDER INFORMATION—*for the primary insured person (parent or spouse if student is the dependent):*

First Name: _____ Last Name: _____

Relationship to Student:

❑ Self ❑ Parent/Guardian ❑ Spouse

I hereby certify the above information is correct. I understand I will not be clear to register for classes until I have emailed a picture or PDF of the front and back of my health insurance card to *health@hiu.edu*.

_____
Signature

Please allow up to 5 business days for processing and holds to be removed. Questions may be directed to the Executive Assistant to the VP of Student Affairs by phone at 714-879-3901 x2311 or by email *health@hiu.edu*.

Health Information/ Emergency Contact/ Notification Service

Student Affairs

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Fullerton, CA 92831 USA
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FAX (714) 681-7224
Email: studentaffairs@hiu.edu

ALLERGIES AND MEDICAL ALERTS

Please list any allergies, chronic illness, or other medical conditions (*if any*) experienced by the student: *(Example: Penicillin, Ibuprofen, Sulfa, Seasonal, Bee Stings, Dust, Peanuts, Pineapple, Bananas, Diabetes, Asthma, Heart Condition)*

Please list current medications prescribed by a physician:

Name of Medicine	Dosage/Frequency	Termination Date

1) _____

2) _____

3) _____

If applicable, please outline any special circumstances we should know about, or special accommodations that you may need during your stay:

EMERGENCY CONTACT INFORMATION

Name _____ Relationship to You _____

Cell Phone _____ Alternate Phone _____

Email _____

Student Signature _____ Date _____

Print Name _____

NOTIFICATION SERVICE

In the event of an emergency situation on campus, you may be notified by text, email, and phone. The following information is needed for the database.

Cell Phone_____ Email_____

Please use this format: 000-000-0000 *This should be an email address that you check often or receive notifications.*

I Live: ❑ At home - I am a commuter student ❑ On-campus in the Alpha dorm ❑ On-campus in the Omega dorm

Student Status: ❑ Traditional Undergraduate ❑ Graduate ❑ ESL ❑ Dorm only

I Attend Classes In: ❑ Fullerton ❑ Anaheim

Print Name _____

OPT-IN TO THE NOTIFICATION SERVICE

To receive text messages you must "opt-in" to the system. Please take a moment to do this now.

1. Send a text message to "67587"
2. In the body of the message, type "YES"
3. After sending the message, you will receive a confirmation message
4. Your service plan needs to have SMS enabled

There is no cost for the service; however, standard message rates may apply.

Name _____

First Name *Middle Initial* *Last Name*

PARENT/GUARDIAN INFORMATION *(If student is under the age of 18 at the time of the event)*

To be filled out by an adult authorized to give permission for the above-named student to receive medical attention.

I, _____ (*please print*), as the ❑ Mother ❑ Father ❑ Legal Guardian (*check one*), of the above-named student, do hereby consent to his/her involvement in the event that my child sustains any condition requiring medical attention (*including, but not limited to diagnostic procedures, surgical treatment, blood transfusions, and dental care*) I consent to the rendering of such treatment by authorized members of the hospital staff or their designees as may in their professional judgment be necessary. I also give my consent to an authorized representative of Hope International University to arrange for any care and treatment necessary to preserve the health of my child.

I understand the contents of this form and agree to all parts that I have not crossed out and initialed. I hereby acknowledge that no guarantees have been made to me as the effect of such examinations or treatment on my child's condition.

I acknowledge that I am responsible for all reasonable charges in connection with the care and treatment rendered during this period and release Hope International University of any liability.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Print Name _____

California Adult Tuberculosis Risk Assessment

- Use this tool to identify asymptomatic **adults** for latent TB infection (LTBI) testing.
- **Do not repeat testing** unless there are **new risk factors** since the last test.
- Do not treat for LTBI until active TB disease has been excluded:
  For patients with TB symptoms or an abnormal chest x-ray consistent with active TB disease, evaluate for active TB disease with a chest x-ray, symptom screen, and if indicated, sputum AFB smears, cultures and nucleic acid amplification testing. A negative tuberculin skin test or interferon gamma release assay does not rule out active TB disease.

LTBI testing is recommended if any of the boxes below are checked.

☐ **Birth, travel, or residence** in a country with an elevated TB rate for at least 1 month

- Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe
- If resources require prioritization within this group, prioritize patients with at least one medical risk for progression (see the California Adult Tuberculosis Risk Assessment User Guide for this list).
- Interferon Gamma Release Assay is preferred over Tuberculin Skin Test for non-U.S.-born persons ≥2 years old

☐ **Immunosuppression,** current or planned

HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication

☐ **Close contact** to someone with infectious TB disease during lifetime

Treat for LTBI if LTBI test result is positive and active TB disease is ruled out.

☐ **None**; no TB testing is indicated at this time.

Provider Name: _____

Assessment Date: _____

Patient Name: _____

Date of Birth: _____

See the California Adult Tuberculosis Risk Assessment User Guide for more information about using this tool. To ensure you have the most current version, go to the TB RISK ASSESSMENT page (https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/TB-Risk-Assessment.aspx)