THE MASTER'S UNIVERSITY

Name _____

Student ID# _____

Health Center
Student Health Record

Personal Information

Name _____
Last *First* *Middle*

Home Address _____
City *State* *ZIP*

Email _____

Home Phone (_____) _____ - _____ **Cell** (_____) _____ - _____

Date of Birth ____/ ____/ _____ **Gender** ☐ Male ☐ Female

Readmit ☐ Yes, I previously attended The Master's University during _____ of _____.
Semester *Year*

Emergency Contact Information

Name _____ **Relationship** _____
Last *First*

Home Address _____
City *State* *ZIP*

Home Phone (_____) _____ - _____ **Cell** (_____) _____ - _____

Work Phone (_____) _____ - _____

Medical Insurance Information

If you have your own medical insurance card you must mail or email a copy of the front & backside to The Master's University Health Center.

☐ I will be covered by The Master's University student insurance.

☐ I am covered by the insurance program listed below:

Please check the appropriate type of insurance:
- ☐ Health Maintenance Org. (HMO)
- ☐ Preferred Prudent Option (PPO)
- ☐ Kaiser
- ☐ Medi-Cal
- ☐ Other

_____
Name of Insurance Company

The Master's University Health Services recommends that every student have health insurance and that you check with your health insurance company to verify coverage in the Santa Clarita, California area. If the insurance is an HMO consider changing the student's Primary Care Physician to a local physician while classes are in session.

Proof of Immunizations

You must email, fax, or mail a copy of your immunization records to the Health Center. The California Department of Public Health requires all students who are enrolled in college to submit proof of immunizations. The documentation should be submitted to the school prior to attendance. The documentation must include the month and year that each vaccine was given. To learn more visit http://www.masters.edu/campuslinks/healthservices/mandatory-immunizations/.

21726 Placerita Cyn. Rd. Box #40 · Santa Clarita, California 91321-1200
(800) 568-6248 · (661) 259-3540 ext. 3765 · healthassistant@masters.edu

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Personal Health History

HAVE YOU HAD?	Yes	No		Yes	No		Yes	No		Yes	No
ADD/ADHD			Cystic Fibrosis			Kidney Disorder			Thyroid Disorder		
Alcoholism/Drugs			Depression			Malaria			Urinary Tract Problems		
Allergies			Diabetes (Type I, II)			Menstrual Problems			Weakness/Paralysis/Fatigue		
Anemia			Dizziness/Fainting			Migraines/Headaches			Other:		
Anorexia			Epilepsy/Seizure			Mononucleosis					
Anxiety (Panic Attacks)			Last Episode:			Multiple Sclerosis			**International Travel**		
Last PA:			Eye Trouble/Glasses			Pneumonia			Location:		
Arthritis			Head Injury			Pregnancy			Date:		
Asthma			Hearing Loss			PTSD					
Back Problems			Heart Condition			Shortness of Breath					
Bulimia			Heart Palpitations			Sinus Problems					
Cancer/Tumor			Hepatitis/Jaundice			Sleep Disorder/Insomnia					
Chest Pain/Pressure			High/Low Blood Pressure			STDs					
Chicken Pox			Hormone Therapy			Stomach/Intestinal Problems					
Chronic Cough			Joint Disease/Injury			Suicidal Thoughts					

If you answered yes to any of the above questions, please explain:

_____

_____

_____

_____

	Yes	No		Yes	No
Have you ever been hospitalized?			Do you have any chronic illnesses?		
Are you currently on any medications?			Do you have any limitations or disabilities?		

If you answered yes to any of the above questions, please explain:

_____

_____

_____

Family Health History

	Yes	No	Relative		Yes	No	Relative
Allergies				High Blood Pressure			
Arthritis				Heart Disease			
Cancer				Kidney Disease			
Diabetes				Psychiatric Disease			
Epilepsy				Other:			

If you answered yes to any of the above questions, please explain:

_____

_____

_____

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Consent for Treatment and Release of Health Information

By signing below, I consent to receive treatment at The Master's University Health Center in the event of illness or injury. I further authorize referral to another medical facility should my injury or illness necessitate it. This consent is to include hospital transport and admission if deemed necessary.

I, the undersigned, further agree it is my responsibility to pay all medical and or hospital expenses incurred beyond those covered by my health insurance policy. The Master's University shall not be held responsible for fees off campus.

I understand and acknowledge, as part of my health care, The Master's University Health Center will originate, record, and maintain my health history, to include: symptoms, examinations, test results, diagnoses, treatment, and future care or treatment plans. I understand and acknowledge that my health information may be used or disclosed by The Master's University Health Center for treatment and healthcare operations. The Health Center will use health information in the following ways:

- A basis for planning my care and treatment
- A means of communication between other healthcare professionals who may assist in my medical care
- A resource for routine healthcare, assessing quality of healthcare, and utilization reviews

I acknowledge and understand that:

- The Master's University Health Center has a Notice of Privacy Practices (HIPAA Law/FERPA), which gives a more complete detailed description of healthcare information and disclosures that I have a right to review. I may request this document at any time.
- The Master's University Health Center reserves the right to change the Notice of Privacy Practices and its policies. Prior to implementing such a change, The Master's University Health Center will mail a paper copy of any revised Notice of Privacy Practices to the address I have provided.
- I have the right to request restrictions as to how my healthcare information may be used or disclosed in order to complete treatment, payment, or healthcare operations.
- The Master's University Health Center is not required to agree to the restrictions requested.
- I may revoke this Consent in writing except to the extent that The Master's University Health Center has already taken action in reliance upon the consent.
- In the case of an emergency or a concern for my wellbeing, or the wellbeing of others, my student's healthcare information can be provided to the Office of Student Life.

By signing this form, I consent to The Master's College University Center's use and disclosure of my health information for treatment and healthcare operations as listed above. Any other use of my personal health information must have my written consent before disclosure to any person.

Additional Permissions:

- ☐ I consent to the release and discussion of my health information to my parents or legal guardians in person or over the phone.
- ☐ I request the following restrictions to the disclosure of my health information:

_____

_____

_____

Student Signature _____ **Date** ____/ ____/ _____

Parent/Legal Guardian Signature _____ **Date** ____/ ____/ _____

(If student is under the age of 18)

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Meningitis Advisory

California law requires that universities make an increased effort to educate students about the risk of Meningococcal disease or "meningitis." Although the incidence of meningitis is relatively rare, studies done by the Center for Disease Control (CDC) and American College Health Association (ACHA) found that cases of Meningococcal disease are three to four times higher among college freshmen that live in dormitories. There are vaccines that help prevent the majority of types of meningococcal disease.

What is Meningococcal Meningitis?

Meningococcal meningitis is a potentially fatal bacterial infection that causes inflammation of the membranes surrounding the brain and spinal cord. It is caused by the bacterium Neisseria meningitides.

How is Meningitis Spread?

Meningitis can be spread by direct contact with infected individuals through respiratory or throat secretions. (Coughing, sneezing, kissing, sharing a glass, eating utensils, or lip balm).

What are the Symptoms of Meningitis?

Early symptoms include high fever, severe headache, stiff neck, rash, nausea, vomiting, lethargy, sensitivity to light and confusion. Symptoms can easily be mistaken for the flu due to meningitis reaching its peak in late winter and early spring, overlapping the flu season.

How is Meningitis Treated?

Bacterial meningitis can be treated with a number of effective antibiotics. It is important however that treatment be started early in the course of the disease. Meningitis progresses rapidly and can lead to death or permanent disability within hours of the first symptoms. Of those who survive, 11%-19% have long term effects. If the individual presents with two or more of the above symptoms they should seek health care immediately.

Is there a Vaccine for Meningitis?

Menactra® and Menveo® are vaccines available in the U.S. that help prevent infection of the most common bacteria, Neisseria meningitides. (Serogroup A, C, Y and W-135). Trumenba® is the latest vaccine for Neisseria meningitides serogroup B (4 strains). Please discuss these vaccines with your personal physician. More information can be found at the websites for the CDC (www.cdc.org) and the ACHA (www.acha.org).

What are the Side Effects of the Meningitis Vaccine?

Meningitis vaccines have an excellent profile. Side effects are mild and infrequent, consisting primarily of redness and swelling at the injection site, lasting up to two days. Immunity lasts 3-5 years.

The Master's University strongly recommends meningitis vaccination for all resident students. For students younger than 21 years old, a vaccination or booster dose must have been given at age 16 years old or older.

Mark on of the boxes and then sign below:

- ☐ I have already received this vaccine. (**Date** _____/ _____/ _____) Please include proof of immunization.
- ☐ I am planning to receive this vaccine and I understand the risk of delaying the vaccination
- ☐ I have read the provided information and do not want to receive any Meningitis vaccine because of personal or religious reasons. Please be aware: in the case of an outbreak, it is plausible that the public health department could mandate quarantine, thereby preventing a non-immunized student from accessing the campus.

Date of Birth _____/ _____/ _____ **Student ID#** _____

Printed Name _____ **Student's Signature** _____ **Date** _____/ _____/ _____

Parent/Legal Guardian Signature _____ **Date** _____/ _____/ _____

(If student is under 18 years of age)

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Part I: Student Tuberculosis (TB) Risk Assessment Questionnaire

Please answer the following six questions:

1) Have you ever had contact with someone who has active Tuberculosis? ☐ Yes ☐ No

2) Were you born in one of the countries or territories listed below that have a high incidence of active TB disease? (If yes, please CIRCLE the country, below) ☐ Yes ☐ No

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
China, Hong Kong SAR
China, Macao SAR
Colombia
Comoros
Congo
Côte d'Ivoire
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
Fiji
French Polynesia
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iran
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia (Federated States of)
Mongolia
Montenegro
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Saint Vincent and the Grenadines
Sao Tome and Principe
Senegal
Serbia
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Swaziland
Tajikistan
Thailand
Timor-Leste
Togo
Trinidad and Tobago
Tunisia
Turkey
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Vietnam
Yemen
Zambia
Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2014. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to http://www.who.int/tb/country/en/.

3) Have you or any household member lived or traveled outside the United States within the last 5 years? ☐ Yes ☐ No

4) Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? ☐ Yes ☐ No

5) Have you been a volunteer or health care worker who served clients who are at increased risk for active Tuberculosis? ☐ Yes ☐ No

6) Do you have any regular contact with those at high risk for Tuberculosis? (e.g., nursing home, prison inmates, homeless, HIV infected individuals or illicit drug/alcohol users.) ☐ Yes ☐ No

Any YES response is considered a positive risk factor. You will be required to have a Mantoux tuberculin skin test (PPD) as soon as possible and proceed to Part II. International students need the test performed 3-6 months prior to arrival on campus.

If the answer to all six questions is NO, no further testing or further action is required

(Complete Parts II and III only if answered YES in Part I)

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Part II: Clinical Assessment by Health Care Provider.

Clinicians should review and verify the information in Part I. Persons answering YES to any of the questions in Part I are a candidate for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented.

If the PPD/TST result is negative:
Please send documentation and no further testing or action is necessary.

If the TB result is positive:
Please send documentation of the result interpretation, physical exam and a chest x-ray to rule out active TB and to be cleared for school. (Must be dated and stamped.)

Date of CXR _____/ _____/ _____ Results_____

Normal _____ Abnormal _____

If the TB result is positive and further management is necessary, refer to Part III.

Part III: Management of Positive PPD/TST or IGRA

All students with a positive PPD/TST or IGRA with no signs of active disease on chest x-ray should receive a recommendation to be treated for latent TB infection (LTBI) with appropriate medication. Please talk over with your physician the increased risk and progression from LTBI to TB disease and make arrangements for any treatment that is prescribed as soon as possible.

Recommendation for plan of care:

_____
_____
_____
_____

_____ Student agrees to treatment.
Initials

_____ Student declines treatment at this time.
Initials

Health Care Professional Signature _____ **Date** _____/ _____/ _____

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