UNIVERSITY
HEALTH CENTER

INCOMING SEMESTER_____
STUDENT ID:_____

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*

MEDICAL INSURANCE INFORMATION

☐ 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)
☐ 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 anything other than a PPO 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 immunizations records to the Health Center. The California Department of Public Health requires all students who are enrolled in college to submit proof of immunizations. **This documentation must be submitted to the Health Center 30 days prior to the start of classes**. The documentation must include the month and year that each vaccine was given. To learn more visit https://www.masters.edu/health-services/

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PERSONAL HEALTH HISTORY

HAVE YOU HAD?	Y	N		Y	N		Y	N		Y	N
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					
Last PA:			Eye Trouble/Glasses			Pneumonia			**International Travel**		
Arthritis			Head Injury			Pregnancy			Location:		
Asthma			Hearing Loss			PTSD			Date		
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:

_____

_____

_____

Allergies:

_____

Current Medications:

_____

Please list any medical conditions other than already noted:

_____

_____

THE MASTER'S UNIVERSITY
21726 PLACERITA CYN. RD. BOX #40 · SANTA CLARITA, CALIFORNIA 91321-1200
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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 may 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?
Meningococcal conjugate (Menactra®, Meveo®, Men Hibrix®), meningococcal polysaccharide vaccine (Menomune®), and Serogroup B meningococcal vaccine (Bexsero®, Trumenba®), are three types of meningococcal vaccines that can help prevent the bacterial Neisseria Meningitis. Please discuss these vaccines with your personal physician. More information can be found at the websites for CDC (www.cdc.org) and the ACHA (www.acha.org).

WHAT ARE THE SIDE EFFECTS OF THE MENINGITIS?
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 one of the boxes and then sign below:

☐ I received this vaccine on or after age 16. (**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 _____

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 questions:

1. Have you ever had close contact with someone who has active Tuberculosis? ☐ Yes ☐ No
2. Have you ever had frequent or prolonged visits (4 weeks or more) to one or more of the countries or territories listed below?
   Please list: _____
3. Were you born in one of the countries or territories listed below that have a high incidence of active TB disease?
   Please list: _____

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

THREE OPTIONS FOR TB CLEARANCE

To be completed by a licensed medical professional if you answered "yes" to any of the above questions. If the answer to all of the questions is "no," Tuberculosis (TB) testing is not required. Testing is requires to have been completed within 3-6 months of arrival on campus.

1. TB Skin Test (PPD)- Must be a Mantoux Test, done in the United States. If the results are positive, see #3 below.
   Date applied: _____ Time Applied: _____ Date Read: _____ Time Read: _____
   Induration: _____mm Impression (circle one): Negative Positive Provider Signature: _____
   Name of Provider or Testing Facility: _____ Provider Telephone #: _____
2. TB Blood Test (QuantiFERON®-TB Gold or T-Spot® TB)
   - Submit a copy of the TB Blood Test results with this form. Worldwide testing and results are accepted.
   - A chest x-ray within one year is required if the TB Blood Test is positive or equivocal. Attach a copy of the chest x-ray report to this form; please do not send actual film.
3. If you have had a positive TB Skin or TB Blood Test:
   - Submit the TB Skin or TB Blood Test results.
   - If you have been treated for latent or active TB, submit documentation of medication, dose, duration, or therapy, and completion date.
   - A chest x-ray within one year is required. Attach a copy of the chest x-ray report to this form; please do not send actual film.

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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 all forms of diagnostic testing and treatment which they deem appropriate, including referral to another medical facility should they judge such further action to be appropriate. This consent is to include hospital transport and admission if deemed necessary. I acknowledge that no representation or guarantees have been made to me as a result of the treatment or care.

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 ("TMU") shall not be held responsible for my medical expenses. In the event of default, I agree to pay all costs of collection, including attorney fees.

I understand and acknowledge, as part of my health care, The Master's University Health Center may originate, record, and maintain my health history, to include: symptoms, examinations, test results, diagnoses, treatment, medications, and/or future care or treatment plans. I understand and acknowledge that my health information, such as records that are considered education records or treatment records under FERPA or those falling under HIPAA, may be used or disclosed by The Master's University Health Center for treatment and healthcare operations, including to outside third parties such as healthcare providers or insurance companies. The Health Center may use health information in accordance with TMU's "Notice of Privacy Practices" (HIPAA/FERPA).

I acknowledge and understand that:

- I have received or I have been provided the opportunity to receive a copy of TMU's "Notice of Privacy Practices", which gives a more complete detailed description of healthcare information and disclosures. I understand that the Notice of Privacy Practices may change over time and that obligations of TMU and my rights under it may change;

NAME_____
STUDENT ID:_____

- 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 options;
- The Master's University is not required to agree to the restrictions requested;
- I may revoke this Consent in writing at any time; however, such revocation shall not be retroactive and shall not apply to the extent that The Master's University has already taken action in reliance upon the Consent;
- My admission to The Master's University is not conditioned upon the execution of this Consent and Release;
- In the case of an emergency or a concern for my wellbeing or the wellbeing of others, my healthcare information can be provided to the Office of Student Care; and
- This Consent, unless extended or replaced in writing, shall expire one year from the date of signature below.

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

PLEASE SIGN ON BACK

_____
Initial

Revised 7/2017

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STUDENT ID:_____

ADDITIONAL PERMISSIONS:

☐ 1. Except as noted in #2 below, I consent to the release and discussion of my health information to my parents or legal guardians in person or over the phone.

☐ 2. 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)

Revised 7/2017

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