PEPPERDINE UNIVERSITY
Graziadio School of Business and Management

STUDENT HEALTH HISTORY
International Graduate Student

Dear Student:
Welcome to Pepperdine! The Student Health Center is here to provide you with medical services that you may need. Please read this form carefully. **PROPER COMPLETION OF THE ENCLOSED INFORMATION IS REQUIRED BEFORE YOU WILL BE ALLOWED TO REGISTER FOR CLASSES**. Print this form, complete, sign, and mail or bring to campus before you are scheduled to begin classes.

1. PERSONAL DATA

All information reported here is confidential and kept as part of your health record in the Student Health Center. The Health Insurance Portability and Accountability Act (HIPAA) protects disclosing your health information. Records cannot by released outside of the Center without your consent, unless by court order. Completion of this questionnaire will enable the medical staff to review your health history, to assist in coordinating your health care.

PLEASE PRINT

TODAY'S DATE / /

NAME Last	First	Middle	SEX	DATE OF BIRTH	MARITAL STATUS	I.D. #

HOME ADDRESS	CITY/STATE/ZIP CODE	PHONE NO. ( )

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY	RELATIONSHIP	PHONE NO. ( )

ADDRESS	CITY/STATE/ZIP CODE

NAME OF PERSONALPHYSICIAN	PHONE NO. ( )

ADDRESS	CITY/STATE/ZIP CODE

2. PERMISSION FOR TREATMENT AND RELEASE OF INFORMATION

In case of routine health examinations, immunizations, diagnostic procedures, treatment of illnesses and/or injuries, permission is hereby granted to treat the student named herein at The Student Health Center, Pepperdine University, and to make necessary referrals for emergency transport or to private physicians, specialists, psychologists, counselors, and or other community facilities as his/her conditions may dictate.

X _____

SIGNATURE OF STUDENT
If the student is under 18 years of age, parental endorsement is also required.

X _____

SIGNATURE OF PARENT

3. HEALTH INSURANCE REQUIREMENT

All international students at Pepperdine's Graziadio School of Business and Management are required to have a current health insurance policy while attending school. If you already have medical insurance, please provide the following information, attach a copy of your policy (with a translation in English) and sign below.

_____
NAME OF INSURED

_____
NAME OF INSURANCE COMPANY

ADDRESS OF INSURANCE COMPNAY	CITY/STATE/ZIP CODE	PHONE NO. ( )

IF A GROUP INSURANCE POLICY, NAME OF GROUP	POLICY OR GROUP NO.

PHARMACY CO-PAY ❑ YES ❑ NO

SIGNATURE _____ DATE _____

X _____

OVER

NAME: **ID #**

4. PERSONAL HEALTH HISTORY

ALLERGIES TO MEDICATIONS

WHAT MEDICAL CONDITIONS HAVE REQUIRED CARE, INCLUDING PERSONAL COUNSELING OR PSYCHOTHERAPY DURING THE PAST 5 YEARS

LIST MEDICATIONS TAKEN RECENTLY OR CURRENTLY

LIST ANY OPERATIONS YOU HAVE HAD AND YEAR (Include tonsils, appendix, hernia, etc.)

OTHER HOSPITALIZATIONS, INCLUDING PSYCHIATRIC HOSPITALIZATIONS (Include reason and year)

5. FAMILY HISTORY

Please indicate if any member of your immediate family (parents, grandparents, siblings) has ever had any of the following:

	LIST RELATIONSHIP		LIST RELATIONSHIP
❑ Heart Disease		❑ Breast Cancer	
❑ Rheumatic Fever		❑ Kidney Disease	
❑ Anemia		❑ Allergy	
❑ Blood Disease		❑ Asthma	
❑ High Blood Pressure		❑ Stomach Trouble	
❑ Stroke		❑ Schizophrenia	
❑ Migraine Headaches		❑ Severe Depression	
❑ Epilepsy		❑ Suicide	
❑ Glaucoma		❑ Cancer	
❑ Diabetes		❑ Tuberculosis	
❑ Thyroid Disease		❑ Other (please explain)	

6. IMMUNIZATION RECORD

STUDENTS PLEASE NOTE: EXTREMELY IMPORTANT!

BE IMMUNIZED, or request appropriate dates from your doctor's records and fill in form.

MANDATORY

Tetanus/diphtheria (booster required within past 10 years) — DATE OF LAST DOSE

Tetanus/diphtheria/ pertussis (Tdap) (required if tetanus booster ≥ 10 years ago

MMR-Measles, Mumps, Rubella — TWO DOSES REQUIRED-First dose 12-15 months ON OR AFTER FIRST BIRTHDAY Second dose at least one month later- MINIMUM 28 DAYS AFTER 1ST DOSE — DATE OF FIRST DOSE — DATE OF SECOND DOSE

The Advisory Committee on Immunization Practice recommend adults receive a single dose of Tdap if they received their most recent tetanus toxoid ≥ 10 years earlier.

Tuberculosis Skin Test (Within past year) — If test has ever been positive, do not repeat. Document date of most recent positive, include size of positive test, and obtain Chest X-ray. — DATE RECEIVED

Reaction: ❑ Negative ❑ Positive mm/induration ____ mm

Chest X-ray - within past year (Required only if T.B. test is positive) — DATE RECEIVED

Findings: _____

Hepatitis B — #1 DATE RECEIVED — #2 DATE RECEIVED — #3 DATE RECEIVED

HIGHLY RECOMMENDED

Meningitis Vaccine — DATE RECEIVED

☐ I decline this vaccination and have read the meningitis information sent to me.

Signed Date

The Center for Disease Control in Atlanta, Georgia and The American College Health Association strongly recommend the vaccination of all college age students with the Meningitis vaccine. Ask your private doctor and be vaccinated against this potentially fatal disease.

NAME OF HEALTH PROVIDER/CLINIC

STREET ADDRESS CITY/STATE /ZIP CODE PHONE NO. ( )

SIGNATURE OF HEALTH PROVIDER (or photocopy of original health immunization record) DATE

X

PLEASE PRINT FORM, SIGN AND BRING TO FRAN GRIMES DURING THE VERBAL WORKSHOP OR SPLASH.
Every box on the Immunization Record MUST be filled in.
DO NOT RETURN BLANK

We look forward to serving you during your stay at Pepperdine. If you have any questions, please call 310-506-4316 & prompt 3. Fax # 310-506-4588 or 310-506-4520.