



Student Health Center
13800 Biola Avenue
La Mirada, CA 90639

P: (562) 903-4841
F: (562) 906-4512

For Office Use Only

Received: ____/____/____

ID #: _____

HEALTH HISTORY FORM

(To be completed by student in black or blue ink.)

Last Name _____ First Name _____ Middle Name _____
Street Address _____ Cell Phone # _____
City, State, Zip Code _____ Date of Birth _____ Age _____
Birthplace _____ Citizenship _____ Ethnicity (opt) _____
Emergency Contact Name _____ Relationship _____ Phone # _____

PERSONAL HISTORY (Please provide approximate dates & details for all "Yes" responses.)

Yes No

- ☐ ☐ ADD/ADHD _____
- ☐ ☐ Anemia _____
- ☐ ☐ Asthma _____
- ☐ ☐ Back Problem _____
- ☐ ☐ Bipolar Disorder _____
- ☐ ☐ Bronchitis, Recurrent _____
- ☐ ☐ Cancer _____
- ☐ ☐ Celiac Disease _____
- ☐ ☐ Chickenpox _____
- ☐ ☐ Counseling _____
- ☐ ☐ Crohn's/Ulcerative Colitis _____
- ☐ ☐ Depression/Anxiety _____
- ☐ ☐ Diabetes _____
- ☐ ☐ Disordered Eating _____
- ☐ ☐ Eye Problem _____
- ☐ ☐ Head Injury/Concussion _____
- ☐ ☐ Headache, Recurrent _____
- ☐ ☐ Heart Condition/Murmur _____

Yes No

- ☐ ☐ High Blood Pressure _____
- ☐ ☐ HIV/AIDS _____
- ☐ ☐ Malaria _____
- ☐ ☐ Menstrual Problem _____
- ☐ ☐ Mononucleosis _____
- ☐ ☐ Orthopedic _____
- ☐ ☐ Pregnancy/Live Birth _____
- ☐ ☐ Pneumonia _____
- ☐ ☐ PTSD _____
- ☐ ☐ Seizures _____
- ☐ ☐ Stomach Disorder _____
- ☐ ☐ Surgery _____
 - ☐ Appendectomy _____
 - ☐ Tonsillectomy _____
 - ☐ Other _____
- ☐ ☐ Thyroid Disorder _____
- ☐ ☐ Tuberculosis _____
- ☐ ☐ Other: _____

Allergies (Medications, Foods, Environmental, etc.): _____ ☐ None

Current Medications: _____ ☐ None

Please list any medical conditions other than already noted: _____ ☐ None

FAMILY HISTORY (Please check any that apply to immediate relatives.)

- ☐ Blood or Clotting Disorders ☐ Depression/Psychiatric ☐ High Blood Pressure ☐ Heart Disease/Stroke ☐ Tuberculosis
- ☐ Cancer ☐ Diabetes ☐ High Cholesterol ☐ Other: _____

Please list any immediate relatives who have died:

	Relationship	Age	Cause of Death
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

AUTHORIZATION FOR TREATMENT OF MINORS (This section is to be completed for students that are under 18.)

I give my consent for my student to receive treatment (for illness or injury), medication, or immunization deemed advisable through the Biola University Student Health Center (BUSHC). I also give consent for the BUSHC to make the necessary referrals to other facilities, if indicated.

Parent/Guardian Signature

Parent/Guardian Printed Name

Date

IMMUNIZATION RECORDS

Biola University does not require students to be immunized in order to maintain enrollment. However, if you have been immunized, we request that you attach a copy of those records to this form in order to maintain an accurate health file.

MENINGITIS ADVISORY

Biola University Student Health Center || 13800 Biola Avenue La Mirada, CA 90639 || P: (562) 903-4841 F: (562) 906-4512

To Students and Parents- In accordance with California state law, Biola University is required to notify you about meningitis (meningococcal disease) and available vaccination. Please read carefully, sign below, and submit to the Student Health Center by the appropriate semester-specific deadline. (FALL SEMESTER: AUGUST 1ST || SPRING SEMESTER: DECEMBER 15TH)

What is Meningococcal Meningitis?

Meningococcal meningitis is a potentially fatal bacterial infection that causes inflammation of the membranes surrounding the brain and spinal cord.

How is the disease spread?

The infection is spread by direct contact with infected individuals, like sharing a drinking glass, eating utensils, or kissing. It is also spread through the exchange of respiratory secretions, like coughing or sneezing. Social aspects of college life, such as close living quarters, students from diverse geographical areas, crowds, and travel to foreign countries are risk factors.

What are the symptoms?

Early symptoms include 1) high fever 2) severe headache 3) stiff neck 4) rash 5) nausea, vomiting and lethargy 5) flu-like symptoms.

Can Meningitis be treated?

Meningococcal 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.

Is there a vaccine against Meningococcal disease?

There is a safe, effective, vaccine called Menactra that can provide long-term protection against four out of five strains of the disease. If you received Menactra between the ages of 11-12, a booster is recommended at age 16. If you received Menactra between the ages of 13-15, a booster is recommended at age 16-18.

What are the side effects of the vaccine? How safe is it?

Menactra vaccine has an excellent safety profile. Side effects are mild and infrequent, consisting primarily of redness and swelling at the injection site, lasting up to two days. The immunization should be deferred during any acute illness. Menactra is preservative-free. If you have any questions regarding the vaccine or disease, please see your doctor or call the Student Health Center at (562) 903-4841. More information can be found at the website for the Center for Disease Control, www.cdc.gov.

Is the Meningococcal vaccine required at Biola University?

No, Biola University does not require students to receive the meningitis vaccine. Since the incidence of bacterial meningitis rises in college freshmen, Menactra vaccine is offered at the Student Health Center for your convenience. Please call the Student Health Center for current prices.

PLEASE CHECK APPLICABLE BOXES AND SIGN BELOW.

For students that have already received the vaccine, or plan to do so, we request that you submit documentation of your vaccination to the Student Health Center.

- ☐ I have already received this vaccination. Date(s) : ____/____/____ and ____/____/____
- ☐ I will receive this vaccine at ☐ Private M.D. ☐ Clinic ☐ Biola University Student Health Center
- ☐ I am choosing to waive this vaccination. I take full responsibility in the event of any possible illness or injury resulting from waiving this immunization. I am aware that in the case of an outbreak of a disease in which I have waived immunization, it is plausible that the Public Health Department could mandate a quarantine, thereby preventing non-immunized students' access to campus.

By signing below, I acknowledge that I have received the above information from Biola University, and certify that the information provided by me is true and correct.

Name _____ Signature _____

Signature of Parent/Guardian (if under 18) _____ Date ____/____/____

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



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Name _____ Date ____/____/____
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TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE

(To be completed by student in black or blue ink.)

1. Have you ever had close contact with someone with infectious TB disease at any time? ☐ Yes ☐ No
2. Were you born in one of the countries listed below that have a high incidence of active TB disease? ☐ Yes ☐ No
(If yes, please circle the country below.)
3. Have you ever lived in or had frequent or prolonged visits (four weeks or more) to one or more of the countries listed below? (If yes, please circle the country below.) ☐ Yes ☐ No

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

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 required to have been completed within one year prior to entrance at Biola University.

1. TB Skin Test (PPD)- **Must be a Mantoux Test, done in the United States.** If 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 Test 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.