Name: _____

Student ID#: _____

THE MASTER'S COLLEGE
For Christ & Scripture

Health Center
New Student Health Record

Personal Information

Name: _____
Last *First* *Middle*

Have you ever been known by another name? _____

Sex *(check one)*:

☐ Male

☐ Female

Academic Standing *(check one)*:

☐ Freshmen ☐ Senior

☐ Sophomore ☐ Transfer Student

☐ Junior

Notice: *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.

Readmission:

☐ I previously attended The Master's College in Year _____.

Email: _____

Home Phone: (_____) _____ -_____

Cell Phone: (_____) _____-_____

Student ID#: _____

D.O.B.: ____/____/_____

Emergency Contact Information:

Name: _____
Last *First*

_____
Street

_____
City *State* *ZIP*

Relationship: _____

Home: (_____) _____-_____

Work: (_____) _____-_____

Cell: (_____) _____-_____

21726 Placerita Cyn. Rd. Box #40 · Santa Clarita, California 91321-1200
(800) 568-6248 · (661) 362-2662 · healthassistant@masters.edu

THE MASTER'S COLLEGE
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Name: _____

Student ID#: _____

Health History

Medical Conditions *(check all that apply, past or present)*:

- ☐ Alcoholism/Drugs
- ☐ Allergies (medicine, insects, pollen, dust)
- ☐ Anemia
- ☐ Anorexia/bulimia
- ☐ Anxiety (panic attacks)
  Date of last panic attack: _____
- ☐ Arthritis
- ☐ Asthma
- ☐ Back pain
- ☐ Cancer/tumor
- ☐ Chest pain/pressure
- ☐ Chicken pox
- ☐ Chronic cough
- ☐ Cystic Fibrosis
- ☐ Depression
- ☐ Diabetes
- ☐ Diabetes medication (insulin)
- ☐ Epilepsy/seizure
- ☐ Eye trouble/glasses
- ☐ Head injury
- ☐ Hearing loss
- ☐ Heart palpitations
- ☐ Heart condition
- ☐ High/low blood pressure
- ☐ Hepatitis/jaundice
- ☐ Joint injury
- ☐ Kidney disorder
- ☐ Malaria
- ☐ Migraines/headaches
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Pneumonia
- ☐ Shortness of breath
- ☐ Sinus problem
- ☐ Sleep disorder/insomnia
- ☐ Stomach/intestinal problems
- ☐ STDs
- ☐ Thyroid disorder
- ☐ Urinary tract problems
- ☐ Weakness/paralysis
- ☐ Other: _____
- ☐ International travel
  Date: _____
  Location: _____

Female Conditions *(check all that apply, past or present)*:

- ☐ Bladder infections
- ☐ Heavy periods/severe cramps
- ☐ Hormone therapy
- ☐ Medication for cramps
- ☐ Pregnancy
- ☐ Other

Please explain all checked answers: _____

_____

_____

Miscellaneous Health Information *(check all that apply)*:

- ☐ I have been hospitalized.
- ☐ I am currently taking medications.
- ☐ I have a chronic illness(es)?
- ☐ I have a limitation(s) or disability(ies).

Please explain all checked answers *(including applicable dates)*: _____

_____

_____

Family History *(check all that apply, past or present)*:

- ☐ Allergies (Relation: _____)
- ☐ Arthritis (Relation: _____)
- ☐ Cancer (Relation: _____)
- ☐ Diabetes (Relation: _____)
- ☐ Epilepsy (Relation: _____)
- ☐ High blood pressure (Relation: _____)
- ☐ Heart disease (Relation: _____)
- ☐ Kidney disease (Relation: _____)
- ☐ Psychiatric disease (Relation: _____)
- ☐ Other (Relation: _____)

Please explain all checked answers: _____

_____

_____

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Medical Insurance

☐ I will be covered by The Master's College Student Insurance.

☐ I am covered by the insurance program indicated below.

- ☐ Elect Choice (EPO)
- ☐ Health Maintenance Organization (HMO)
- ☐ Point of Service (POS)
- ☐ Preferred Provider Organization (PPO)
- ☐ Private
- ☐ Medi-Cal

Note: Unless the student submits an insurance waiver online, all students are automatically enrolled in health insurance, sponsored by The Master's College and managed by Wells Fargo Insurance Services. Waivers will be approved based on the health plan. Students must submit a waiver once per academic year. Please check the Health Center webpage for applicable deadlines.

Once your insurance waiver has been approved, please email or mail a copy of the front and back of your insurance I.D. card so we can keep it in your file.

This form is solely for The Health Center's information, and ***DOES NOT constitute signing the waiver or enrolling with The Master's College Insurance***. Please check the Health Center webpage for instructions on submitting your insurance waiver electronically. (Include a printed copy of the waiver with the rest of your health forms.)

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Name: _____

Student ID#: _____

Consent for Treatment and Release of Health Information

I give my consent to receive treatment at The Master's College Health Center in case of illness and/or injury, and I give authority to make the necessary referrals to other facilities if indicated. Consent is further given for admission to a hospital for medical or surgical treatments as ordered by a physician. It is agreed that all medical and/or hospital expenses incurred beyond those covered by any applicable health insurance policy will be paid directly by the undersigned student and parent or guardian, and that the College will not be held responsible.

I understand and acknowledge that as part of my health care, The Master's College Health Center originates, records, and maintains health information about me describing my health history, symptoms, examinations, test results, diagnoses, treatment, and any plans for future care or treatment. I understand and acknowledge that this health information may be used or disclosed by The Master's College 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 tool for routine healthcare operations, such as assessing quality of healthcare operations and utilization review

I acknowledge and understand that:

- The Master's College Health Center has a Notice of Privacy Practices (HIPAA Law), 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 College Health Center reserves the right to change the Notice of Privacy Practices and its policies. Prior to implementing such a change, The Master's College 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 College 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 College Health Center has already taken action in reliance upon the consent.
- In case of emergency or threat to student's safety, a student's healthcare information can be provided to the VP of Student Life and/or the Deans.

By signing this form, I consent to The Master's College Health 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: _____

_____

_____

Signature of Patient: _____ Date: ____/____/_____

Signature of Parent/Legal Guardian: _____ Date: ____/____/_____

(If student is under 18)

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THE MASTER'S COLLEGE
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Name: _____

Student ID#: _____

Meningitis and Immunization Advisory and Notification

The following information is offered as a guide to assist you in understanding the Meningococcal disease and immunization benefits.

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 the disease spread? How can college students protect themselves?

The infection is spread by direct contact with infected individuals (e.g. kissing, sharing a glass, eating utensils, or lip balm). It is also spread through exchange of respiratory secretions like coughing or sneezing. Students can protect themselves by exercising, maintaining good hygiene, eating a well-balanced diet, and not skipping meals. They should wash their hands frequently.

What are the symptoms?

Early symptoms include high fever, severe headache, stiff neck, rash, nausea, vomiting, lethargy, and flu-like symptoms.

Can Meningitis be 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.

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.

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

Menactra vaccine has an excellent profile. Side effects are mild and infrequent, consisting primarily of redness and swelling at the injection side, 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. More information can be found at the Center for Disease Control website, www.cdc.gov.

We will keep this confidential file as part of your medical records in the Health Center in accordance with Assembly Bill 1452.

Please indicate your preference and acknowledgement of this information by signing below:

☐ I have already received this vaccine. (Date ____/____/_____) Please include proof of immunization.
☐ I am planning to receive this vaccine.
☐ I do not want to receive this 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: ____/____/_____
Student's Printed Name Student Signature

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

Signature of Parent/Legal Guardian: _____ Date: ____/____/_____
(if student is under 18)

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