COMPLETION OF THESE FORMS IS A REQUIREMENT FOR CLASS REGISTRATION, NCAA, CLUB SPORTS, AND STUDY ABROAD PARTICIPATION.

All health forms for CLASS REGISTRATION must be received by the Health Center three weeks prior to the beginning of the school year. Class enrollment will be jeopardized if health information is incomplete. NOTE: All medical information is confidential; however, we reserve the right to discuss immunization matters with parents unless a written request not to do so is provided.

This Physical Exam is for (select all that apply): □ New Student □ NCAA Sports □ Club Sports □ Study Abroad

☐ I plan to participate in intercollegiate/NCAA-sanctioned athletics and or club sports, and I hereby grant permission to Emmons Health Center to share copies of my health history and physical exam with the Occidental College Athletics Department.

_____________________________  __________________________
SIGNATURE OF STUDENT (REQUIRED) DATE
HEALTH HISTORY  To be completed by STUDENT

LAST NAME (PRINT), FIRST, MIDDLE                      GENDER:  
□ F  □ M  □ F, M

HOME ADDRESS

HOME CITY, STATE, ZIP

ENTERING OXY AS A:  
□ Fr.  □ So.  □ Jr.  □ Sr.

EMAIL ADDRESS

MOBILE PHONE

In Case of Emergency, Contact:

LAST NAME (PRINT), FIRST, MIDDLE                      RELATIONSHIP                      HOME PHONE

(  )

HOME ADDRESS

BUSINESS PHONE

(  )

HOME CITY, STATE, ZIP

MOBILE PHONE

(  )

Family Health History

<table>
<thead>
<tr>
<th>Has anyone in your biological family had any of the following?</th>
<th>Yes</th>
<th>No</th>
<th>Age Diagnosed</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer (specify type)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>High blood pressure/high cholesterol</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart attack or other heart problems</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Mental illness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol/chemical or drug dependency</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Other</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Personal Health History

<table>
<thead>
<tr>
<th>Have you experienced or are now experiencing any of the following?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Have you received treatment?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Did your treatment include: (Please check all that apply)</th>
<th>Counseling</th>
<th>Medication</th>
<th>List Medication(s)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Dates of treatment &amp; notes</th>
<th></th>
</tr>
</thead>
</table>

Anxiety

Bipolar disorder

Depression

Obsessive Compulsive Disorder

Panic disorder

Phobia

Suicide attempt

Anorexia

Binge or compulsive eating

Bulimia

Schizoaffective disorder

Other

Do you plan to continue, resume, or begin receiving care for these problems while at Oxy?  
□ Yes  □ No

Describe: ____________________________________________

TOBACCO USE:  
□ Yes  □ No  If Yes, _______ pack(s) per day for _______ years.

ALCOHOL USE:  
□ Yes  □ No  How often?_______________ Average number of drinks on each occasion?_______

(continued next page)
HEALTH HISTORY Continued

Have you experienced, or are now experiencing any of the following?

<table>
<thead>
<tr>
<th>ADD/ADHD</th>
<th>GERD</th>
<th>Palpitations</th>
<th>Surgery (describe below)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia</td>
<td>Hay fever</td>
<td>Pneumonia</td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td>High blood pressure</td>
<td>Prostheses</td>
<td></td>
</tr>
<tr>
<td>Chicken pox</td>
<td>High cholesterol</td>
<td>Rheumatism or arthritis</td>
<td></td>
</tr>
<tr>
<td>Collitis/Crohn's disease</td>
<td>Irritable bowel syndrome</td>
<td>Scarlet fever</td>
<td></td>
</tr>
<tr>
<td>Convulsions/seizures</td>
<td>Malaria</td>
<td>Skin disorders</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>Marfan's syndrome</td>
<td>Stomach or duodenal ulcer</td>
<td></td>
</tr>
<tr>
<td>Ear, nose and throat problems</td>
<td>Migraine/chronic headache</td>
<td>Tuberculosis</td>
<td></td>
</tr>
<tr>
<td>Excessive fatigue</td>
<td>Measles/Mumps/Rubella</td>
<td>Urinary tract infection</td>
<td></td>
</tr>
<tr>
<td>Glasses/contact lenses</td>
<td></td>
<td>Mononucleosis</td>
<td></td>
</tr>
</tbody>
</table>

*Describe any surgeries, fractures, or heart conditions with date of onset and treatment and current care (if applicable):

List any illness, condition or injury, not listed above, for which you are now being treated:

List any medications you take routinely (including birth control pills and nonprescription medications including nutritional supplements):

ALLERGIES:  Yes  No  (Please list any allergies to medications, foods, insect stings, pollen, or other environmental factors)

1. Yes  No  Has a doctor ever denied or restricted your participation in sports for any reason?

2. Yes  No  Have you ever passed out or nearly passed out during or after exercise?

3. Yes  No  Have you ever experienced excessive shortness of breath or pain, discomfort or pressure in your chest during exercise?

4. Yes  No  Does your heart race or skip beats during or after exercise?

5. Yes  No  Have you ever had a neck or back injury?

6. Yes  No  Does any family member have heart problems or have died from heart problems or sudden death before age 50 or become disabled?

7. Yes  No  Have you had any test on your heart including EKG, echocardiogram or others? If yes, when was it done? What were the results?

8. Yes  No  Have you ever had a head injury or concussion? If yes, how many times? When was the most recent occurrence?

9. Yes  No  Do you have a seizure disorder? If yes, when was your most recent occurrence?

10. Yes  No  Do you cough, wheeze or have difficulty breathing during and after exercise?

11. Yes  No  Do you have severe muscle cramps or become ill when exercising in heat?

12. Yes  No  Do you have a regular menstrual period? (females) When was your last menstrual cycle?

IMPORTANT INFORMATION – PLEASE READ AND COMPLETE

Statement by Student: I have personally supplied the above Health History information and attest that it is true and complete to the best of my knowledge. I understand that this information is strictly confidential and will not be released to anyone without my written consent unless by court order. However, if I should be ill or injured and unable to sign the appropriate forms, I hereby give my permission to Emmons Health Center healthcare providers to release information from my health record to another provider(s), hospital, or other medical agency involved in providing me with emergency treatment and/or medical care.

SIGNATURE OF STUDENT (REQUIRED)  DATE
FINANCIAL RESPONSIBILITY AND PERMISSION FOR TREATMENT

IMPORTANT INFORMATION – PLEASE READ AND COMPLETE

NOTE: The Financial Responsibility and Consent to Treatment must be signed by both the student and parent.

I hereby accept financial responsibility for the expense of healthcare services, which are rendered to the aforementioned student by Emmons Health Center or such other healthcare provider as Emmons Health Center shall deem necessary or desirable.

I hereby give permission for the aforementioned student to receive general non-surgical medical treatment from Emmons Health Center or such other healthcare provider as Emmons Health Center shall deem necessary or desirable.

______________________________  ________________
SIGNATURE OF STUDENT (REQUIRED)  DATE

______________________________  ________________
SIGNATURE OF LEGAL RESPONSIBLE PARENT OR GUARDIAN (REQUIRED)  DATE
**PHYSICAL EXAM** To be completed by the **PROVIDER (MD, DO, NP, PA)**

Patient Last Name ________________________ First ________________________ Date ________________________

Birthdate _______________ M □ F □ T/I □ Height ___________ Weight ___________ % of Body Fat (optional) ___________

Year in School: FR □ SO □ JR □ SR □ Sport (if applicable) ____________________________

Pulse _______ BP _____/_____ _____ /_____ Temp __________

Vision R 20/______ L 20/______ Corrected: Y □ N □ Pupils: Equal _____ Unequal _____

<table>
<thead>
<tr>
<th>Objective</th>
<th>Normal</th>
<th>Abnormal</th>
<th>Description/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin/body marks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes, ears, nose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulse (femoral)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mouth, teeth, and throat</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neck</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest/lungs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart/murmurs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitourinary (males)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurological</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MUSCULOSKELETAL</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Appearance</td>
<td></td>
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<td></td>
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<tr>
<td>Neck</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Shoulder/arm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elbow/forearm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wrist/hand/fingers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip/thigh</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knee</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leg/ankle</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foot/toes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**EKG – only if indicated.** □ Normal □ Abnormal (specify)

This Physical Exam is for (select all that apply): □ New Student □ NCAA Sports □ Club Sports □ Study Abroad

Please check one of the following boxes if this Physical Exam is also being used to CLEAR a student to participate in athletic sports or travel for a study abroad program.

☐ This student is **CLEARED** to participate in athletics or sports and/or travel for a study abroad program in _____ (country).

☐ This student is **CLEARED** to participate in athletics or sports and/or travel for a study abroad program in _____ (country) ONLY if the FOLLOWING RECOMMENDATIONS are met:

☐ This student is **NOT CLEARED** to participate in athletics or sports and/or travel for a study abroad program.

**PROVIDER NAME (PRINT/TYPED)_________________________ DATE_________________________

ADDRESS __________________________ PHONE ____________________________ MD, DO, NP, PA

**PROVIDER SIGNATURE ___________________________**
IMMUNIZATION RECORD To be completed by a HEALTH CARE PROVIDER

Name: ____________________________  ____________________________  ____________________________  ____________________________
(PLEASE PRINT)  LAST  FIRST  MIDDLE

Birthdate: ____________________________  ____________________________  ____________________________  ____________________________

MUST BE COMPLETED AND SIGNED BY HEALTH CARE PROVIDER
All information must be in English.

A. M.M.R. (MEASLES, MUMPS, RUBELLA) – Two doses required.
1. Dose 1 given at age 12 months or later: #1 ___ / ___ / ___
2. Dose 2 given at least 28 days after first dose: #2 ___ / ___ / ___

B. POLIO – Three primary series are required.
1. OPV alone (oral Sabin three doses):
   #1 ___ / ___ / ___  #2 ___ / ___ / ___  #3 ___ / ___ / ___
2. IPV/OPV sequential:
   IPV #1 ___ / ___ / ___  IPV #2 ___ / ___ / ___  OPV #3 ___ / ___ / ___  OPV #4 ___ / ___ / ___
3. IPV alone (injected Salk four doses):
   #1 ___ / ___ / ___  #2 ___ / ___ / ___  #3 ___ / ___ / ___  #4 ___ / ___ / ___

C. VARICELLA – Required
(Birth in the U.S. before 1980, a history of chicken pox, a positive varicella antibody, or two doses of vaccine meets the requirement.)
1. History of disease  ☐ Yes  ☐ No  or  Birth in U.S. before 1980  ☐ Yes  ☐ No
2. Varicella antibody ___ / ___ / ___  Result:  ☐ Reactive  ☐ Non-reactive
3. Immunization (Dose #2 given at least 12 weeks after first dose ages 1-12 years and at least 4 weeks after first dose if age 13 years or older.)
   Dose #1 ___ / ___ / ___  #2 ___ / ___ / ___

D. TETANUS, DIPHTHERIA, PERTUSSIS – Required
1. Primary series completed?  ☐ Yes  ☐ No
   Date of last dose in series: ___ / ___ / ___
2. Date of most recent booster dose: ___ / ___ / ___
   Type of booster: Td ___  Tdap ___
   Tdap booster recommended for ages 11-64 unless contraindicated.

E. MENINGOCOCCAL QUADRIVALENT – Required
(A, C, Y, W-135) One or 2 doses for all college students. Need booster dose if received first dose at age of 15 or younger.
   Quadrivalent conjugate (preferred; administer simultaneously with Tdap if possible).
a. Dose #1 ___ / ___ / ___  b. Dose #2 ___ / ___ / ___

(continued next page)
IMMUNIZATION RECORD Continued

F. HEPATITIS A (strongly recommended) 2 doses at least 6-12 months apart.
1. Immunization (hepatitis A)
   a. Dose #1 _____ / _____ / _____
   b. Dose #2 _____ / _____ / _____
2. Immunization (Combined hepatitis A and B vaccine)
   a. Dose #1 _____ / _____ / _____
   b. Dose #2 _____ / _____ / _____
   c. Dose #3 _____ / _____ / _____

G. HEPATITIS B – Required
(Three doses of vaccine or two doses of adult vaccine in adolescents 11-15 years old, or a positive hepatitis B surface antibody.)
1. Immunization (hepatitis B)
   a. Dose #1 _____ / _____ / _____
   b. Dose #2 _____ / _____ / _____
   c. Dose #3 _____ / _____ / _____
2. Immunization (Combined hepatitis A and B vaccine)
   a. Dose #1 _____ / _____ / _____
   b. Dose #2 _____ / _____ / _____
   c. Dose #3 _____ / _____ / _____
3. Hepatitis B surface antibody Date _____ / _____ / _____ Result: □ Reactive □ Non-reactive

H. HUMAN PAPILLOMAVIRUS VACCINE (HPV) – Three doses of vaccine (recommended for male and female students).
   a. Dose #1 _____ / _____ / _____
   b. Dose #2 _____ / _____ / _____
   c. Dose #3 _____ / _____ / _____
Quadrivalent (HPV4) _____ or Bivalent (HPV2) _____

I. INFLUENZA – Strongly recommended
a. Date _____ / _____ / _____

J. PNEUMOCOCCAL POLYSACCHARIDE – Recommended
(One dose for members of high risk groups, including smokers and asthmatics.)
a. Date _____ / _____ / _____

I. TUBERCULOSIS SCREENING
REQUIRED within 12 MONTHS PRIOR TO FIRST DAY of CLASSES.
(A history of BCG vaccination should not preclude testing)

TB skin test Date Administered: _____ / _____ / _____ Date Read: _____ / _____ / _____
Results: □ Positive □ Negative mm (required)
Signature of Health Care Provider ______________________________________________________

CXR (required if tuberculin skin test has a positive reaction > 10 mm)

Date _____ / _____ / _____ Normal _________ Abnormal _________ *If abnormal, attach copy.

HEALTH CARE PROVIDER (not immediate family member)

Print Name: ____________________________ Date ____________________________

Signature: ____________________________

Address: ____________________________

Phone: ____________________________
Emmons Health Center is a combined facility, providing both medical and mental health treatment to the students of Occidental College. At Emmons, we acknowledge the connection between mental and physical health, and strive to provide integrated services. Specifically, we feel that we are most effective when members of our multidisciplinary treatment team share health-related information with one another.

All staff practicing at Emmons are licensed by the State of California, or are supervised by licensed professionals. In addition to acknowledging ethical standards of both the medical and counseling fields, the Health Center as a whole follows the State of California’s laws regarding privacy. These laws essentially state that an individual receiving medical or psychological treatment must authorize any disclosures of information outside of specific exceptions. These are the situation and circumstances in which your information will be shared:

- Emergency medical conditions
- Imminent risk of harm to self
- Imminent risk of harm to others
- Reasonable suspicion of dependent adult/child abuse
- In response to a court order, or
- In response to a public health event

Additionally, Emmons Health Center adheres to the provisions of the Health Insurance Portability and Accountability Act (HIPAA) with respect to protecting the privacy of the information you disclose to us. However, we may use and disclose your health information for the purposes of: insurance billing, communicable disease reporting (to public health authorities), and internal quality assurance measures.

By signing below, therapists and medical staff will have the opportunity to share information regarding your health status in a manner that is appropriate and in your best interest.

Please note that we will not disclose information to individuals or agencies outside of the Health Center (including school administrators, faculty, and other students) without your approval, or as part of one of the previously noted exceptions. You may make written request for copies of your health records from the Health Center at any time.

This authorization will remain in effect throughout the duration of your education at Occidental College. You may choose to revoke this authorization at any point by speaking with your Emmons healthcare provider.

My signature below indicates that I have read, understand, and consent to the Authorization to Share Information within the Health Center.

Student Name:_________________________________________ Date of Birth:______________

(PLEASE PRINT)

Student Signature:______________________________________ Date:________________

If student is under the age of 18:

Parent Name:_________________________________________ Date of Birth:______________

(PLEASE PRINT)

Parent Signature:______________________________________ Date:________________
MUTUAL ARBITRATION AGREEMENT

Patient’s Name: ________________________________

(PLEASE PRINT)

This Mutual Arbitration Agreement constitutes an integral part of a contract for medical services by and between the Healthcare Providers(s) who have or may agree to be bound hereunder and the Patient:

1. It is understood that any dispute as to medical malpractice, that is, as to whether any medical services rendered under this Contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this Contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

2. Such arbitration shall be in accordance with the current Medical Arbitration Rules of the California Medical Association and California Hospital Association (copies available at Emmons Health Center). This Mutual Arbitration Agreement shall apply to any legal claim or civil action in connection with this medical service against any healthcare provider who has agreed to be bound by this provision.

3. The execution of this Mutual Arbitration Agreement shall not be a precondition of the furnishing of service by the Healthcare provider, and this Mutual Arbitration Agreement may be rescinded by written notice from the Patient or Patient’s representative to the Healthcare provider within 30 days of signature.

4. This Mutual Arbitration Agreement shall bind the parties hereto, including newborns, and the heirs, representatives, executors, administrators, successors, and assigns of such parties and newborns.

5. Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

   Initials: ________________________________

   (PATIENT OR PATIENT’S REPRESENTATIVE)

Effect as of the date of first medical services.

If any provision of this arbitration agreement is determined to be invalid or unenforceable, the remaining provisions shall remain in full force.

Notice: By signing this contract you are agreeing to have any issue of medical malpractice decided by neutral arbitration and you are giving up your right to a jury or court trial. See Article 1 of this contract.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature, I acknowledge that I have received a copy.

Patient Signature: ________________________________ Date: ______________

(PATIENT/PARENT/CONSERVATOR/GUARDIAN)

If signed by other than patient, indicate relationship: ________________________________

Signature of Medical Professional: ________________________________ Date: ______________

(HEALTHCARE PROVIDER OR AUTHORIZED REPRESENTATIVE)

Emmons Health Center, Occidental College