



### Claremont Graduate University Medical History Report

**Completion in full regardless of your status (i.e. part-time, exchange, or transfer student) is required for registration at any of The Claremont Colleges.** This form must be submitted by July 15<sup>th</sup> for students beginning in the Fall semester and by January 15<sup>th</sup> for students beginning in the Spring semester. Upload the completed form to <http://cgucompliance.com/>.

Please note that **required** immunizations and screening include:

- COVID – up-to-date on series
- Measles, Mumps, and Rubella (MMR) - two dose series
- Primary series of Tetanus, Diphtheria, Pertussis and Tdap booster within the last 10 years
- Tuberculosis screening questionnaire (TB skin test, CXR, or Quantiferon blood test to be performed, if indicated)
- Varicella Zoster (VZV) - 2 dose series or date of disease

Immunization records are required to prevent outbreaks of disease on campus as well as to help recognize students who are at risk should a disease outbreak occur. **If you cannot locate your immunization records, you have two options:**

- You can be re-immunized.
- You can have a blood test to determine immunity for MMR and VZV. If the blood test indicates you are not immune to MMR or VZV you will have to be re-immunized.

Once your form has been completed, upload it to CGU's medical repository at: <INSERT LINK> .

Thank you for your cooperation. Your compliance helps protect the health of the entire campus community.

**To be completed by Health Care Provider Only:**

Patient Name: \_\_\_\_\_

**Tuberculosis screening**

All students from high prevalence areas for tuberculosis, or otherwise high-risk, must have a health care provider complete the form below or submit a report documenting a negative tuberculin skin test, a negative (normal) chest x-ray, or Interferon Gamma Release Assay (blood test) from a health care provider. A student with a positive tuberculin skin test, current or past, must submit a chest x-ray report. The report must be written in English, have the date of the skin test, x-ray, or blood test and have the name and the signature of the health care provider.

**A. TUBERCULOSIS SCREENING (Required)**

1. Does the student have a history of a positive tuberculin skin test (PPD) in the past?  Yes  No  
 If no, proceed to #2.  
 If yes, include date of positive PPD, mm induration, date and results of most recent chest x-ray and documentation of any treatment received for latent tuberculosis. **Skin test should not be repeated.** Proceed to #2.
2. Does the student have signs or symptoms of active tuberculosis disease?  Yes  No  
 If no, proceed to #3.  
 If yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.
3. Is the student a member of a high-risk group?  Yes  N

**High-risk groups include the following:**

- Students who were born in or resided in countries where TB is endemic.
  - As it is easier to identify countries of low rather than high TB prevalence, students should undergo TB screening if they were born in or resided in countries **EXCEPT** Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia, USA, Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand.
- Students with HIV infection.
- Students who inject drugs.
- Students who have resided in or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters.
- Students with clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunioileal bypass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone ≥ 1 month) or other immunosuppressive disorders.

**If you have answered no to questions 1-3, please skip the following section.**

**If you have answered yes to questions 1-3, please continue:**

Place tuberculin skin test [Mantoux only: Inject 0.1 ml of purified protein derivative (PPD) tuberculin containing 5 tuberculin units (TU) intradermally into the volar (inner) surface of the forearm]. A history of BCG vaccination should not preclude testing of a member of a high-risk group.

Tuberculin Skin Test: (Must be performed within 6 months of arrival on campus)

Date Placed: \_\_\_\_\_ Date Read: \_\_\_\_\_

Result: \_\_\_\_\_ Record actual mm of induration, transverse diameter; if no induration, write "0".

Interpretation (Based on mm induration as well as risk factors.): Positive  Negative

**Or** Interferon Gamma Release Assay (IGRA): Date Obtained: \_\_\_\_\_

(Specify Method):  QFT-G  QFT-GIT Other: \_\_\_\_\_

Result:  Positive  Negative  Indeterminate

Chest x-ray result (Required only if tuberculin skin test in #3 or IGRA is positive): Date of CXR: \_\_\_\_\_

Result:  Positive  Negative



To be completed by Health Care Provider Only

Patient Name: \_\_\_\_\_

**Immunization Record: (Please fill out below OR attach copy of the immunization record)**

**Required**

**COVID-19** Students must provide proof of vaccination, or approval for an exemption, at least 2 weeks prior to visiting campus. Complete even when uploading the Covid-19 vaccination card.

\_\_\_\_\_ #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 Vaccine \_\_\_\_\_

**MMR** (measles/mumps/rubella) – dates of vaccine or laboratory report of immunity

\_\_\_\_\_ #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 or Report of Positive Immunity

Persons born before 1957 are considered immune; all others should receive at least one dose of MMR vaccine)

**Td or Tdap** (tetanus/diphtheria/pertussis) – booster recommended every ten years

Date of last immunization \_\_\_\_\_

**Varicella** (chickenpox) – history of disease or dates of vaccine or laboratory report of immunity

\_\_\_\_\_ #1 \_\_\_\_\_ #2 or Date of Disease \_\_\_\_\_

**Recommended**

**Hepatitis B --**

\_\_\_\_\_ #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3

**Hepatitis A --**

\_\_\_\_\_ #1 \_\_\_\_\_ #2

**Meningococcal Tetravalent (MCV4)**

Tetravalent conjugate (preferred)

Tetravalent polysaccharide

Date of last immunization \_\_\_\_\_

Booster \_\_\_\_\_

**Human Papillomavirus** (2, 4, or 9 valent)

\_\_\_\_\_ #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3

**Polio**

\_\_\_\_\_ #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ #4 \_\_\_\_\_ Last Booster

**Influenza**

Date of last immunization \_\_\_\_\_

**Name of Health Care Provider (Please print):** \_\_\_\_\_

**Provider**

**Address:** \_\_\_\_\_

**Street**

**City**

**State**

**Zip**

**Provider Phone #:** \_\_\_\_\_ **Provider Fax#** \_\_\_\_\_

**Signature of provider:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Stamp of provider:**