Claremont Graduate University

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 15th for students beginning in the Fall semester and by January 15th 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: http://cgucompliance.com/**.**

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

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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 jejunoileal 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

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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 polysaccaride
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: