San Diego Christian
A College Founded on Truth.

OFFICE USE ONLY:
STUDENT ID ____________________
ADVISOR ____________________

# HEALTH FORM

**Admissions Office**
200 Riverview Parkway
Santee, California 92071
**(619) 201-8700 · (800) 201-8749**
sdcc.edu

ALL students are required to provide the following information. It is kept confidential and maintained as a part of a student's medical record in Health Services. Information cannot be released to anyone without express permission from the student concerned.

## PERSONAL INFORMATION

1. Are you a returning student to SDCC? ❍ NO ❍ YES What year/semester were you previously enrolled? ____________________
2. Social Security Number ________ - ________ - ________ Date of birth (MM/DD/YY) ____________________
3. Gender: ❍ Male ❍ Female
4. ____________________
   Last Name (legal name) First Middle
5. ____________________
   Address
6. ____________________
   City State Zip Country
7. ____________________
   Home Phone Cell Phone
8. ____________________
   E-mail Address
9. ____________________
   Parent/Guaridan Name
10. ____________________
    Address/City/State/Zip of Parent/Guardian if different from above

## INSURANCE INFORMATION & MEDICAL RELEASE

11. Emergency Contact Name ____________________ Phone ____________________
12. Accident/Health Insurance Company ____________________
13. Group/Policy Number ____________________ Insurance Company Phone ____________________
14. Personal Physician ____________________ Phone ____________________
15. ____________________
    Address/City/State/Zip of Personal Physician

## PERMISSION FOR TREATMENT

In case of routine health examination, immunization, diagnostic procedure, treatment of illness and/or injuries, permission is hereby granted to treat the student named below at the Health Services Office at San Diego Christian College, and to make necessary referrals to private physicians and other community facilities as indicated.

16. Student First and Last Name ____________________

16. Student Signature ____________________ Date ____________________
    **Type Signature above.** *By checking this field applicant acknowledges use of his/her electronic signature and verifies that all information is true and correct..*

17. Parent or Legal Guardian Signature ____________________ Date ____________________
    *(Required if student is under 18)*

*continued on reverse*

# PERSONAL HEALTH

Please rate the following:

| | *Excellent* | *Good* | *Poor* |
|---|---|---|---|
| General Health | ❍ | ❍ | ❍ |
| Eyesight | ❍ | ❍ | ❍ |
| Hearing | ❍ | ❍ | ❍ |

HEIGHT________ ft_______ in WEIGHT ___________ lbs

Previous Surgeries: ____________________________________________________

____________________________________________________

____________________________________________________

Previous Serious Injuries: ____________________________________________________

____________________________________________________

____________________________________________________

Do you have any physical limitations? ❍ YES ❍ NO

If yes, explain: ____________________________________________________

____________________________________________________

Have you ever had a serious reaction to a bee sting? ❍ YES ❍ NO

If so, describe the reaction: ____________________________________________________

____________________________________________________

____________________________________________________

Are you currently under the care of a physician for any health problems?
*(e.g. diabetes, high blood pressure, depression, eating disorders, asthma, or allergies)*

❍ YES ❍ NO

If yes, please state the condition and treatment: ______________________________

____________________________________________________

____________________________________________________

Are you currently using any medications on a regular basis? ❍ YES ❍ NO

If yes, please explain: ____________________________________________________

____________________________________________________

____________________________________________________

____________________________________________________

Are you allergic to any medications? ❍ YES ❍ NO

If yes, please list: ____________________________________________________

____________________________________________________

____________________________________________________

____________________________________________________

*California law requires that all students read, respond to, and sign the following:*

# MENINGITIS INFORMATION

Meningococcal disease is caused by Neisseria Meningitidis bacteria. The two most common forms of meningococcal disease are meningitis, a bacterial infection of the fluid and covering of the spinal cord and brain; or septicemia, an infection of the bloodstream. It is relatively rare. Common symptoms include stiff neck, headache, fever, sensitivity to light, sleepiness, confusion, and seizures. It can lead to brain damage, disability, and death. College-aged students, particularly those living in residence halls, have a modestly increased risk of getting the disease. For this reason, the American College Health Association has adopted the guidelines set forth by the Advisory Committee of Immunization Practices. These guidelines encourage dissemination of information regarding this disease and vaccination availability to those who wish to reduce the risk of meningococcal disease. For more information visit the Department of Health Services for the State of CA website, www.dhs.ca.gov.

## Check One:

❍ I intend to receive the meningococcal vaccine from my family physician or public health center.

❍ I have already received the meningococcal vaccine.

❍ I do not intend to receive the meningococcal vaccine.

Student name printed____________________________________________________

Signature ____________________________________________________

Date ____________________________________________________

Immunizations are required by San Diego Christian College. They may be obtained through private physicians or local health departments. If you are opposed to immunizations due to religious or medical reasons, please attach supporting documentation to this form.

**Prior to admission to the College, all students are REQUIRED to have:**

- TB Skin Test (Tuberculosis) administered no earlier than 1 year prior to arrival on campus.

  Month _________ Year__________ ❍Positive ❍Negative

*If positive, please provide evidence of negative chest x-ray or treatment plan.*

- Tetanus-Diptheria Booster required within the last 10 years.

  Month _________ Year__________

- MMR (Measles/Mumps/Rubella) 2 required

1st - Month _____________ Year____________ (age 12-15 mo. or older)

2nd– Month ____________ Year____________ (age 4-6 years or older)

SDCC and the American College Health Association strongly recommend but do not require the following vaccines:
Hepatitis B series, Hepatitis A series, Meningococcal, Varicella, and Polio.

*Contact your physician for information.*

Signature ____________________________________________________

Date ____________________________________________________

**Type Signature above.** *By checking this field applicant acknowledges use of his/her electronic signature and verifies that all information is true and correct..*

Please inform Health Services regarding any major health changes during your enrollment at SDCC. Questions can be directed to the College nurse at (619) 201-8700.