



Student Health History and Insurance Assessment

Student Affairs

2500 E. Nutwood Ave.
Fullerton, CA 92831 USA
(714) 879-3901 x2311
FAX (714) 681-7224
Email: health@hiu.edu

Last Name: _____ First Name: _____ Middle Name: _____

ID#: _____ Date of Birth: ____/____/____ Age: ____ Gender: Male Female

1. IMMUNIZATION RECORD

PLEASE SUPPLY DATES OF IMMUNIZATIONS AND PLEASE UPDATE IF NEEDED

Tetanus-Diphtheria (booster within the last 10 years. _____)

MMR (Measles, Mumps, Rubella) Dose 1 _____ Dose 2 _____ (two dates required by HIU)

Measles (Rubeola): disease date _____ Mumps: disease date _____ Rubella: disease date _____

Polio: Completed primary series? (4 dates) Yes ___ Date of last booster _____ If NO, get completed series.

Hepatitis A Dose 1 _____ Dose 2 _____ (two dates required)

Hepatitis B Dose 1 _____ Dose 2 _____ Dose 3 _____ (three dates required)

Mantoux Tuberculosis Test (within the past year) Date Applied _____ Date Read _____ Results _____

If POSITIVE, must have chest x-ray within 2 years. Date of CXR _____ Results _____

Menactra A/C/Y/W - 135 (Meningococcal vaccine) _____

2. VERIFICATION BY CLINICIAN OF PAST INFECTION (CLINICIAN-PLEASE INDICATE MONTH AND YEAR)

Measles _____	Rubella _____	Hepatitis B _____	Clinician Signature _____
---------------	---------------	-------------------	---------------------------

3. BLOOD TEST In lieu of vaccinations, you may provide proof of immunity by checking the appropriate box(es) and **attaching lab results to this form.**

Serologic confirmation (blood titer) of immunity **attached**: Measles Rubella Hepatitis B

4. MEDICAL EXEMPTION (Physician/Clinician please check appropriate box)

I certify that the medical circumstances of the above-named student contraindicate immunization against:

Measles & Rubella Hepatitis B

Physician/Clinician signature Date Clinic stamp if applicable

5. OTHER EXEMPTION (Religious or personal exemption-must be reviewed with the health center director by appointment only.)

a) I request a personal/religious exemption from vaccinations for the following reason:

Student Signature: _____ Date: _____ Director Signature: _____

OR

b) I certify that I was born prior to January 1, 1957, and attended primary and secondary school in the United States, will not reside in a campus residence hall (dorm) and will not work with pre-school age children or health care patients as part of my college experience.

Student Signature: _____ Date: _____

I understand that exemption for any of the reasons listed above subjects me to exclusion from campus in the event of an outbreak of a disease for which immunization is required.

Emergency Contact in the USA:

Last Name _____ First Name _____

Relationship _____

Address _____ Street _____

Apt# _____ City _____ State _____ Zip _____

Phones (WK/HM/CELL) _____

Allergies:

Medications _____

Others: _____

Medical Alerts:

Student Signature _____ Date _____

Health Insurance Information/Enrollment Form For School Year 2010 - 11



STUDENT AFFAIRS
(714) 879-3901 ext. 2311
FAX (714) 681-7224

Last Name _____ First Name _____ Middle Name _____

Student of: PCC SGPS Other _____

Hope International University requires that ALL Pacific Christian College students enrolled in 7 units or more, or living in on-campus housing, have health insurance. Students may elect to enroll in the Student Insurance Plan, or waive this opportunity by listing a viable health insurance alternative below. PCC students who fail to meet the waiver requirements upon application, will automatically be enrolled in the student plan, and charged a \$25 late fee. Students enrolled in SGPS may elect to enroll in the Insurance Plan.

ENROLLMENT IN THE HEALTH INSURANCE PLAN IS MANDATORY FOR ALL INTERNATIONAL STUDENTS.

STUDENT INSURANCE PLAN - ENROLLMENT - This means that I need Student Insurance

Domestic \$506/per semester \$1,011.00/annual International \$678/per semester \$1,355.00/annual

* Students must be enrolled and actively attending classes in each semester to be eligible for coverage. Election of coverage does not guarantee coverage if not actively attending.

Check mark the plan you have selected—for family coverage complete application below.

Annual: Fall Semester: Spring/Summer:

***A policy benefits brochure may be requested from the Student Affairs, (714) 879-3901 x2311**

SUPPLEMENTARY APPLICATION FOR FAMILY COVERAGE

I wish to extend my own coverage to include my following dependents (spouse and unmarried children under age 19 who are residing with me).

Dependent's Name	Date of Birth	Relationship to Insured
_____	_____	_____
_____	_____	_____

By signing this enrollment request, I hereby authorize the Student Health Service to release to United Healthcare and/or its representatives, any information regarding my medical history and treatment necessary to process any insurance claims.

Student Signature _____ Date _____
(Signature of Parent/Guardian if student is under 18 years of age)

STUDENT HEALTH INSURANCE - WAIVER

I waive the opportunity to enroll in The Student Insurance Plan because I have viable health insurance with:

Insurance Company: _____ Policy Number: _____

A copy of your medical insurance card (front and back) must be provided.

Please answer the following questions and sign below:

Is this a family policy?	No ___	Yes ___	Are you covered after age 18?	No ___	Yes ___
Are you covered for accident?	No ___	Yes ___	Are you covered for sickness?	No ___	Yes ___
Does your policy cover visits to the doctor's office?	No ___	Yes ___	Will your policy pay total costs?	No ___	Yes ___
Are there geographic limitations precluding service in Orange County?	No ___	Yes ___	Does your policy coverage assist with prescription costs?	No ___	Yes ___

Student Signature _____ Date _____
(Signature of Parent/Guardian if student is under 18 years of age)

ENTRANCE IMMUNIZATION REQUIREMENTS

Hope International University Board of Trustees requires that:

- > **ALL STUDENTS born on or after January 1, 1957**, show proof of full immunization against measles (rubeola) and rubella. Certain groups of students **regardless of age** must also show proof of full immunization. These groups include: students who attended K-12 school outside the US, students who have lived outside the US at any time during the last 10 years, and all students who will live in the campus residence hall.
- > All new enrollees who are **18 years of age or younger** show proof of having completed a 3 dose series of immunizations against Hepatitis B.

Immunity to Measles (Rubeola) and Rubella means:

Two doses of measles and rubella given individually or in combination (MR or MMR) at or after 12 months of age and at least one month apart.

Immunity to Hepatitis B means:

Three doses of Hepatitis B vaccine given over a period of approximately 6 months.

Compliance with these requirements can be met in the following ways and **needs to be completed prior to your next registration period:**

A. Submit Documentation

Send one or more of the following documents **to the Student Affairs Office** with your name and Student ID# clearly indicated on each document submitted:

- The form on the reverse side (or similar form) **completed by your physician or health care provider**
- A photocopy of your childhood immunization record
- A photocopy of your California High School transcript **IF** immunization information is documented on transcript
- A copy of a lab report showing proof of immunity by blood titer

B. Be Immunized

If you don't have documentation, be immunized at:

- Your family physician
- A local clinic or County Public Health Department

C. Request a waiver or exemption

- **Medical:** If your medical circumstances contraindicate immunization, have your physician sign the statement on the reverse side of this form (or similar form) and return it to the Health Center.
- **Religious:** State law permits exemption from immunization for those who object to immunizations on religious or personal grounds. These waivers are handled on a case-by-case basis and require an appointment with the Director of Student Health for approval.

D. Student Statement of Exemption

If you were born prior to January 1, 1957, and attended K-12 in the US, have not lived outside the US at any time during the last 10 years, and will not reside in a campus residence hall (dorm), **please sign the student statement of exemption (#5b)** on the next page of this form.

**Mail or FAX your completed forms and documentation to: Hope International University • Student Affairs
2500 E. Nutwood Avenue • Fullerton, CA 92831 • FAX: (714) 681-7224
Or email your completed forms and documentation to: health@hiu.edu**

After filling out BOTH SIDES of this form send to Student Affairs

Revised as of 05-10