

Please complete and print, then mail, FAX, or bring to the ISHC prior to registering. Non-completion will result in a hold on your account which will prevent you from registering.

3201 Campus Dr., Klamath Falls, Oregon 97601; Phone: 541-885-1800 Fax: 541-885-1866

NAME: _____
First Last Middle

OIT ID # 918- _____ DATE OF BIRTH: _____ BIRTH PLACE: _____

GENDER: _____ If gender other than birth sex, what was birth sex? _____ Telephone number we can call to reach you _____

Person to be notified in an emergency: _____ Relationship: _____ Phone: _____

Medications: List any medicines you take regularly, including over the counter medications or supplements _____

Allergies: Medications, latex, food, insects etc.: ☐ Yes ☐ No Please list: _____

Are you a tobacco smoker? Yes ☐ No ☐ If so, how often? _____ How much? _____ What age did you start? _____

Do you drink alcohol? Yes ☐ No ☐ If so, how often? 3 or fewer times a month Once a week or more **How many drinks/week?** 1 to 2 3 to 5

6 to 9 10+

Personal Medical History:

Please check any of the following as it applies to you:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Allergies (seasonal) | <input type="checkbox"/> Head Injury or Concussion | <input type="checkbox"/> Physical Limitations | <input type="checkbox"/> Stomach or Intestinal Problem |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Back Problem | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Serious Injuries (with date) | <input type="checkbox"/> Visual Problems |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Sexually Transmitted Infection | <input type="checkbox"/> Other |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Skin Disorder | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Splenectomy | |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Muscle/Joint problems | | |

Please explain any items you have checked above and date of occurrence: _____

Hospitalizations and Surgeries (with reasons and dates): _____

Mental Health History

Please check any of the following as it applies to you:

- | | | |
|--|--|---|
| <input type="checkbox"/> Act of Self-Harm (cutting, branding, etc) | <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Panic Disorder |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Autism Spectrum | <input type="checkbox"/> PTSD/History of trauma |
| <input type="checkbox"/> Alcohol or Substance abuse or dependence | <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Sleep Disorder |
| <input type="checkbox"/> Anger Problems | <input type="checkbox"/> Depression | <input type="checkbox"/> Suicidal Ideation |
| <input type="checkbox"/> Anti-Social or Conduct Disorder | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Other |
| | <input type="checkbox"/> Learning Disability | |
| | <input type="checkbox"/> Obsessive-Compulsive Disorder | |

Are you now taking or have ever taken medication for any of the above? ☐ Yes ☐ No

Specific medications and dates _____

Do you intend to begin or continue counseling during college? ☐ Yes ☐ No

Have you been hospitalized for a psychiatric disorder? ☐ Yes ☐ No

Have you been treated for alcohol and/or drug addiction? ☐ Yes ☐ No

Family Medical History

Please mark the following if there is a history in your immediate blood relatives, e.g. parents, siblings or grandparents.

- | Relationship | Relationship | Relationship |
|--|---|--|
| <input type="checkbox"/> Breast Cancer _____ | <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Convulsions/Seizures _____ |
| <input type="checkbox"/> Other Cancer _____ | <input type="checkbox"/> Death before 50 _____ | <input type="checkbox"/> Bleeding Disorders _____ |
| <input type="checkbox"/> Stroke/Blood Clots _____ | <input type="checkbox"/> High Cholesterol _____ | <input type="checkbox"/> Mental Health Condition _____ |
| <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Alcohol or Drug Abuse _____ |

*All information disclosed on this form will be kept confidential and will be shared with appropriate college personnel on a need-to know basis only.

Please complete and print, then mail, FAX to, or e-mail to ISHC **before you register**. Non-completion will result in a hold on your account.

Name (Last, First, Middle) _____

Student ID # 918 _____

Required Vaccinations for Admission:

Per Oregon Administrative Rule 333-050-0130: All entering university students born on or after January 1, 1957 will have **two doses of MMR** (measles, mumps, rubella) which are at least 24 days apart and the first dose was up to 4 days prior to or after the student's first birthday. **Documentation is required for these immunizations.** Indicate which of the following documentation you have attached to this form (copies are acceptable):

- Doctor's office or medical clinic records Public Health Department records
Your high school or previous college immunization records Personal immunization card signed by clinic staff
Serological Confirmation of Immunity: Lab test (titer) for Measles, Mumps, and Rubella may be substituted as proof of immunity in lieu of vaccinations. Copies of lab work must be attached.

If the information submitted regarding MMR vaccinations is incomplete or insufficient, a hold will be placed on your account, preventing you from registering. You may refer to "University Services" in the eneral Catalog for more information.

International students: You must have at least 1 documented MMR vaccine on file before being allowed to register.

Required Tuberculosis Exposure Information:

- Have you ever had close contact with persons known or suspected to have active TB disease? ☐ Yes ☐ No
- Were you **Born** in one of the countries listed below that have a high incidence of active TB disease*? If yes, check "**B**" below next to your birth country. ☐ Yes ☐ No
- Have you had frequent/prolonged **Visits** to 1 or more of the countries listed below? Check "**V**" for each ☐ Yes ☐ No

| B | V | | B | V | | B | V | | B | V | | B | V | | B | V | | B | V | |
|---|---|----------------------------------|---|---|---------------------------------------|---|---|----------------------------------|---|---|----------------------------------|---|---|--------------------------------|---|---|------------------------------------|---|---|--|
| | | Afghanistan | | | Cameroon | | | Gabon | | | Libya | | | Palau | | | Sri Lanka | | | |
| | | Algeria | | | Central African Republic | | | Gambia | | | Lithuania | | | Panama | | | Sudan | | | |
| | | Angola | | | | | | Georgia | | | Madagascar | | | Papua New Guinea | | | Suriname | | | |
| | | Argentina | | | Chad | | | Ghana | | | Malawi | | | Paraguay | | | Swaziland | | | |
| | | Armenia | | | China | | | Guatemala | | | Malaysia | | | Peru | | | Tajikistan | | | |
| | | Azerbaijan | | | Colombia | | | Guinea | | | Maldives | | | Philippines | | | Thailand | | | |
| | | Bahrain | | | Comoros | | | Guinea-Bissau | | | Mali | | | Poland | | | Timor-Leste | | | |
| | | Bangladesh | | | Congo | | | Guyana | | | Marshall Islands | | | Portugal | | | Togo | | | |
| | | Belarus | | | Côte d'Ivoire | | | Haiti | | | Mauritania | | | Qatar | | | Trinidad & Tobago | | | |
| | | Belize | | | Democratic People's Republic of Korea | | | Honduras | | | Mauritius | | | Republic of Korea | | | Tunisia | | | |
| | | Benin | | | | | | India | | | Mexico | | | Republic of Moldova | | | Turkey | | | |
| | | Bhutan | | | Democratic Republic of the Congo | | | Indonesia | | | Micronesia (Federated States of) | | | Romania | | | Turkmenistan | | | |
| | | Bolivia (Plurinational State of) | | | | | | Iran (Islamic Republic of) | | | Mongolia | | | Russian Federation | | | Tuvalu | | | |
| | | Bosnia & Herzegovina | | | Djibouti | | | Iraq | | | Morocco | | | Saint Vincent & The Grenadines | | | Uganda | | | |
| | | Botswana | | | Dominican Republic | | | Kazakhstan | | | Mozambique | | | Sao Tome & Principe | | | Ukraine | | | |
| | | Brazil | | | Ecuador | | | Kiribati | | | Myanmar | | | Serbia | | | United Republic of Tanzania | | | |
| | | Brunei Darussalam | | | El Salvador | | | Kuwait | | | Namibia | | | Seychelles | | | Uruguay | | | |
| | | Bulgaria | | | Equatorial Guinea | | | Kyrgyzstan | | | Nauru | | | Sierra Leone | | | Uzbekistan | | | |
| | | Burkina Faso | | | Eritrea | | | Lao People's Democratic Republic | | | Nicaragua | | | Singapore | | | Vanuatu | | | |
| | | Burundi | | | Estonia | | | Latvia | | | Niger | | | Solomon Islands | | | Venezuela (Bolivarian Republic of) | | | |
| | | Cabo Verde | | | Ethiopia | | | Lesotho | | | Nigeria | | | Somalia | | | Viet Nam | | | |
| | | Cambodia | | | Fiji | | | Liberia | | | Niue | | | South Africa | | | Yemen | | | |
| | | | | | | | | | | | Pakistan | | | South Sudan | | | Zambia | | | |
| | | | | | | | | | | | | | | | | | Zimbabwe | | | |

* Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2012. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to <http://apps.who.int/ghodata>

- Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? ☐ Yes ☐ No
- Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB? ☐ Yes ☐ No
- Have you ever been a member of any of the following groups that may have an increased incidence of latent *M. tuberculosis* infection or active TB disease: medically underserved, low-income, or someone who abused drugs and/or alcohol? ☐ Yes ☐ No

If the answer to all of the above questions is NO, no further testing or further action is required.

If the answer is YES to any of the above questions, Oregon Tech requires that you receive TB testing as soon as possible but at least prior to the start of the subsequent quarter. Please see our website for details.

- If you are providing documentation of a TB skin test, was it performed after exposure to any of the above identified risks in Questions 1 through 6? ☐ N/A ☐ Yes ☐ No

| |
|--------------------|
| Office Use |
| TB complete _____ |
| MMR complete _____ |