DHARMA REALM
BUDDHIST UNIVERSITY

Health Data

Please note: Students will not be allowed to register for classes until all required health data are submitted and evaluated, including proof of insurance. Health data should be received by Sunday June 30, 2024. Please complete all sections to the best of your knowledge.

ALL INFORMATION REQUESTED ON THIS FORM IS STRICTLY CONFIDENTIAL AND ESSENTIAL TO EVALUATING YOUR HEALTH STATUS.

If a student has a chronic health problem, including mental illness, that is not adequately managed and controlled, he/she could be asked to take a medical leave of absence in order to address the health concerns if the student is unable to meet academic standards or the standards of conduct of the University, including, but not limited to, the Student Code of Conduct, the Student Housing Agreement, and the Student Service Scholarship Agreement. Please ensure that all chronic health conditions are under good control before the start of the semester and that you receive clearance from your doctor to attend school.

Name of student _____ Date of birth _____ Gender _____

Phone _____ Address _____

I certify that all of the following health data is factually true and honestly presented.

Student Signature _____ Date _____

Health Insurance Requirement

As Dharma Realm Buddhist University refers students with illness/injury, except minor ones, to local facilities for medical care and/or hospitalization, it is required that all students maintain comprehensive health insurance coverage. Please attach a copy of both sides of your insurance card to this form and provide the following information:

Insurance company _____ Policy number _____

Permission to Examine and Treat

In case of illness and/or injury, permission is granted to examine and treat the undersigned student at the Dharma Realm Buddhist University clinic and to make referrals to outside physicians and facilities.

Student Signature _____ Date _____

Parent/Guardian Signature** _____ Date _____

**If student is under 18 years of age, parent or guardian must also sign.

Name of student _____

Personal Health Information

Physical activity restrictions due to medical condition (please be specific)

_____

All medications you are now taking _____

Any treatment you are presently receiving (injections, physiotherapy, etc.) _____

_____

Allergies (drugs, food, environmental, latex, etc.) _____

Recent surgeries or medical problems _____

Name of your physician _____ Phone _____

Date of last physical exam _____ Results _____

_____

Recommendations _____

Immunization Information

Please note: DRBU Health Services requires that all students present proof of immunity to measles and rubella. Attach immunization records to this page. Tetanus and Diphtheria boosters should be received every 10 years throughout life. Meningococcal Meningitis should be given within the last three years.

☐ I have attached my immunization records.

(OR)

☐ I hereby request exemption from ☐ all ☐ some, as noted below, immunization requirements for school entry because of allergy or because some immunizations are contrary to my beliefs. I am aware of the symptoms and consequences of these diseases and should I develop any one of these, I accept the responsibility to obtain medical help immediately.

☐ Measles	☐ Polio	☐ Varicella (chicken pox)
☐ Mumps	☐ Diphtheria/Tetanus	☐ Hepatitis A
☐ Rubella	☐ Tdap	☐ Hepatitis B
☐ MMR	☐ Tetanus Toxoid	☐ Meningococcal Meningitis*
☐ COVID-19	☐ Other	

*An additional form, included in the packet, must be signed for exemption from Meningococcal Meningitis Vaccine.

If you have not signed a waiver of immunization is it required that you submit proof of immunization.

Name of student _____

Meningococcal Vaccine Policy

Students will need to have proof, signed by their health care provider, of having received the meningitis vaccine prior to their arrival for the start of the school year. Meningococcal disease is a potentially fatal bacterial infection commonly referred to as meningitis.

The CDC Advisory Committee on Immunization Practices recommends all students receive this vaccine. It is particularly advised for all students living in a dormitory environment, where the risk of transmission is higher due to the close quarter living conditions.

At DRBU our goal is to safeguard the wellbeing of all of our students, and this is why we ask all students who will be residing in the dorms to make sure they arrange for this vaccination before the start of the fall semester.
For more information please see the California Meningococcal Fact Sheet:

http://eziz.org/assets/docs/IMM-688.pdf

I have read and understood the DRBU Meningococcal Vaccine Policy.

Student Signature _____ Date _____

Meningococcal Vaccine Requirement

Name of Student _____

Date of Birth _____

I have received the meningococcal vaccine as required by DRBU for students residing on campus. Documentation from my health care provider is attached.

Signature of Student or Parent/Guardian if student under the age of 18 _____

Date _____

Waiver for individuals under the age of 18:

I have received and reviewed the information provided on the risks of meningococcal disease and the effectiveness and availability of the meningococcal vaccine. I understand that meningococcal disease is a rare but life threatening illness. I understand that DRBU requires that a student who resides in on-campus student housing receive the vaccination unless a waiver to the vaccination is signed.

I choose to waive the receipt of meningococcal vaccine for my child, _____

Signature of Parent/Guardian _____ Date _____

Waiver for individuals age 18 or older:

I am 18 years of age or older. I have received the information on the risk of meningococcal disease and the effectiveness and availability of meningococcal vaccine. I understand that meningococcal disease is a rare but life threatening illness. I understand that DRBU requires that a student who resides in on-campus student housing receive the vaccination unless a waiver to the vaccination is signed.

I choose to waive the receipt of meningococcal vaccine.

Signature of individual _____ Date _____

Name of student _____

Student Health History

Foreign travel

Country _____ Date _____ Country _____ Date _____

Country _____ Date _____ Country _____ Date _____

Please indicate the date of first occurrence of any of the following conditions, if applicable.

_____ Anemia	_____ Asthma	_____ Blood clotting disorders
_____ Bruising disorders	_____ Chicken Pox	_____ Colitis
_____ Diabetes	_____ Emotional/Mental Illness	_____ Epilepsy
_____ Heart Disease	_____ Hepatitis	_____ Hypertension
_____ Kidney disease	_____ Malaria	_____ Meningitis
_____ Mononucleosis	_____ Pneumonia	_____ Poliomyelitis
_____ Rheumatic fever	_____ Thyroid disease	_____ Tuberculosis
_____ Typhoid fever	_____ Close association with tuberculosis	_____ COVID-19
_____ Other		

Details of any illnesses indicated above: _____

Dharma Realm Buddhist University

Please check yes or no to the following:

General	Yes	No
Recent weight change	☐	☐
Amount +/- _____		
Unusual fatigue	☐	☐

Digestive	Yes	No
Abdominal pain	☐	☐
Indigestion	☐	☐
Bowel trouble	☐	☐
Liver trouble	☐	☐
Gall bladder trouble	☐	☐
Jaundice	☐	☐

Female Only	Yes	No
Vaginal discharge	☐	☐
Lumps in breast	☐	☐
Menstrual problems:		
Irregularity	☐	☐
Interferes w/work	☐	☐

Allergies	Yes	No
Medicines	☐	☐
Specify _____		
Foods	☐	☐
Specify _____		
Plants, animals, etc.	☐	☐
Specify _____		

Emotional	Yes	No
Under care of psychiatrist	☐	☐
Under care of psychologist	☐	☐
Ever had psychiatric care?	☐	☐
Ever hospitalized for emotional problems?	☐	☐
Ever medicated for emotional problems?	☐	☐

Male Only	Yes	No
Penile discharge	☐	☐
Hernia	☐	☐
Undescended testicle	☐	☐
Swelling of testicle	☐	☐

*If any "yes" boxes are checked, please give specific history, including dates, medications, or other treatment. Also indicate if any of those conditions are currently being treated.

Please check yes or no to the following:

Eyes	Yes	No
Discharge	☐	☐
Blurring	☐	☐
Double vision	☐	☐
Injury	☐	☐
Impaired vision	☐	☐

Throat	Yes	No
Hoarseness	☐	☐
Post-nasal drip	☐	☐

Ears	Yes	No
Pain	☐	☐
Ringing	☐	☐
Discharge	☐	☐
Itching	☐	☐
Perforation of drum	☐	☐
Impaired hearing	☐	☐

Skin	Yes	No
Eczema	☐	☐
Fungus	☐	☐
Rash	☐	☐
Open sores	☐	☐

Nose	Yes
No	
Obstruction	☐ ☐
Sneezing	☐ ☐
Bleeding	☐ ☐

Nervous System	Yes
No	
Dizziness	☐ ☐
Convulsions	☐ ☐
Unconsciousness	☐ ☐
Paralysis	☐ ☐

Heart & Lungs	Yes	No
Chest pain	☐	☐
Difficulty in breathing	☐	☐
Persistent coughing	☐	☐

Muscles, Joints, Bones	Yes
No	
Pain	☐ ☐
Stiffness	☐ ☐
Swelling	☐ ☐
Limited motion	☐ ☐
Varicose veins	☐ ☐
Deformity	☐ ☐

Kidneys	Yes
No	
Painful urination	☐ ☐

Have you had any serious injuries, illnesses, or surgeries? ☐ Yes ☐ No

If yes, give the date, nature, and resulting complications/limitations. You may continue onto the back of this page if needed.

Name of student _____

Family Health History

Please answer all questions.

Family Health History

Father Living: ☐ Yes ☐ No (If deceased, please note cause) _____

Age: _____ State of health: _____ Occupation: _____

Note any special health problems: _____

Mother Living: ☐ Yes ☐ No (If deceased, please note cause) _____

Age: _____ State of health: _____ Occupation: _____

Note any special health problems: _____

Brothers ☐ Yes ☐ No

Note any special health problems: _____

Sisters ☐ Yes ☐ No

Note any special health problems: _____

If there has been a history of any of the following illnesses in your family, please check:

☐ allergies	☐ anemia	☐ arthritis	☐ asthma	☐ blindness
☐ cancer	☐ deafness	☐ diabetes	☐ eczema	☐ epilepsy
☐ hay fever	☐ high blood pressure	☐ heart disease	☐ mental illness	☐ tuberculosis
☐ thyroid disease	☐ ulcers	☐ other: _____		

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To the student: Please arrange an appointment with your licensed healthcare provider and give him/her this form to complete. DRBU Health Services does not provide routine examinations. A dental checkup is also advised.

Once the form is complete, please submit it to DRBU Health Services via health.services@drbu.edu (email) or 707-402-8842 (fax).

Name of Student _____ Age _____

Weight _____ Height _____ P. _____ B.P. _____

Normal/Abnormal Details

Skin _____ Heart _____

Eyes _____ Lungs _____

Ears _____ Abdomen _____

Nose _____ Back _____

Mouth & Teeth _____ Extremities _____

Throat _____ Speech _____

Neck _____ Nervous System _____

Thyroid _____

Lab work if indicated:

Hemoglobin _____ Hematocrit _____ Serology _____

Urine: Albumen _____ Glucose _____ Microscopic _____

Other _____

Your assessment of the student's general condition:

_____

_____

Does the student have any restrictions regarding full participation in classroom activities, dormitory living, physical activities and sports?

_____

_____

Provider Signature _____ Date _____

Provider Name _____ Phone _____

Address _____

Tuberculosis Clearance Form
(to be completed by licensed healthcare provider)

To the student: DRBU Health Services requires that all students present current TB status. TB clearance may not be waived. All TB testing must be done within the previous 12 months by a licensed healthcare provider.

Name of student _____

Date of birth _____

Tuberculin Test: Date _____ Type _____ Result _____

Chest X-ray*: Date _____ Result _____

*Students who have positive TB test results must get a chest x-ray and have their licensed healthcare provider fill out the attached Tuberculosis Health Assessment Form.

Provider Signature _____ Date _____

Provider Name _____

Phone _____

Tuberculosis Health Assessment Form
(to be completed by licensed healthcare provider)

To the student: If you have a positive Tuberculin skin test result, you must have a licensed healthcare provider complete and return this form to DRBU Health Services.

Name of Student _____

Date of Birth _____

History Questions (All questions must be answered)	YES	NO	If YES, do indicated test:
Did the student ever receive the BCG vaccine?	☐	☐	Perform test #2
Has the student ever had a positive TB skin test?	☐	☐	Perform test #2 or #3
Does the student have any of these risk factors:			
A) Recent contact with anyone with active TB	☐	☐	Perform test #1, or #2 if
B) Immunosuppressed: organ transplant, HIV	☐	☐	there is a history the
C) Born in or ever resided in or traveled to a high risk area, including anywhere in Asia, Africa, South America, Central America, Middle East, Eastern Europe.	☐	☐	BCG vaccine if yes for ABC
D) History of abnormal chest x-ray	☐	☐	Perform test #3 and #4 if chest x-ray is abnormal
Does the student have signs/symptoms of active TB? (Cough greater than 2 weeks, chest pain, unexplained weight loss, night sweats or fever)	☐	☐	Perform #1 or #2 (and #3 and #4, if indicated)
Has the student ever been treated for Latent Tuberculosis Infection (LTBI)?	☐	☐	If yes, perform test #3

Medication _____

Start date _____ Completion date _____

#1. Tuberculin Skin Test (TST) (>5mm is positive if yes to A, B or F; otherwise >10mm is positive)

Date placed: _____ Date read: _____ Result: _____ mm induration

Interpretation: negative _____ positive _____ (If positive, proceed to #3, CXR)

#2. TB Blood Test (Interferon Gamma Release Assay—IGRA) recommended if history of BCG vaccine: if not available may do a TST or chest x-ray (CXR)

Date obtained: _____ Result: Negative _____ Positive _____

(If positive or indeterminate, proceed to #3, CXR)

#3. Chest X-ray (Required if TST or IGRA is positive) * Must attach report*

Date of CXR _____

Result: normal _____ abnormal _____ (any abnormal must perform sputums—proceed to #4)

#4. Sputum Results (AFB smears and cultures x 3 are required if the chest x-ray is read as abnormal)

Date #1 _____ AFB _____ Culture _____ Date #2 _____ AFB _____ Culture _____

Date #3 _____ AFB _____ Culture _____

Provider Signature _____ Date _____

Provider Name _____

Phone _____

Address _____