Admissions Office

ArtCenter College of Design
1700 Lida Street, Pasadena, CA 91103 626 396-2373 artcenter.edu

Student Health Information

Instructions for Accepted Student

It is your responsibility to send this completed form, including a negative tuberculosis test, to the Admissions Office prior to New Student Orientation. This information is important in the event that you have a medical emergency while at ArtCenter. Your ability to enroll and register may be affected if the form is not recieved prior to the start of the term. Please consult with Student Support Services in the Center for the Student Experience concerning any special health-related accommodations you may need.

Section 1: General Information

Name

Last First Middle

Date of Birth Email

Permanent Home Address

Street Telephone

City State ZIP

Residence while attending ArtCenter College of Design

Street Telephone

City State ZIP

Emergency Contact

Name Relationship

Street Telephone

City State ZIP

Primary Health Care Provider

Name

Street Telephone

City State ZIP

Section 2: Tuberculosis Testing

ArtCenter requires verification of a negative tuberculosis result within the last six months. Please have a licensed medical physician verify the results of your tuberculosis screening test below, accompanied by a test result letter or by a physician's office stamp.

Tuberculosis X-Ray or PPD Results: ○ Positive ○ Negative

Physician's signature Date

Student Health Information Form

Section 3: Medical History (To be completed by the student)

1	Allergic reaction to food, insect bites or other	○ Yes	○ No	6	Chicken Pox	○ Yes	○ No
2	Mumps	○ Yes	○ No	7	Tuberculosis	○ Yes	○ No
3	Mononucleosis (Mono)	○ Yes	○ No	8	Operation or serious injury	○ Yes	○ No
4	German Measles (Rubella)	○ Yes	○ No	9	Hospitalization	○ Yes	○ No
5	Hard Measles (Rubella)	○ Yes	○ No	10	X-ray therapy to the head or neck	○ Yes	○ No

Details: Identity questions by number and include diagnosis; age or dates; and treatment.

Describe any ongoing health conditions or problems requiring medical attention:

List any medications you take regularly:

Adverse or allergic reaction to any medication:

Have you ever had or been treated for any of the following:

1	Serious disease of eye, nose or throat	○ Yes	○ No	7	A sexually transmitted infection (STI)	○ Yes	○ No
2	Frequent or severe headaches or convulsions, or a severe head injury	○ Yes	○ No	8	Diabetes, thyroid or other endocrine disorder	○ Yes	○ No
3	Lung diseasse, asthma, persistent cough or shortness of breath	○ Yes	○ No	9	Anemia or other disorder of the blood	○ Yes	○ No
4	High blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels	○ Yes	○ No	10	Bone, joint or muscle problem; back pain; arthritis; physical deformity; or paralysis	○ Yes	○ No
5	Frequent or severe abdominal pain, hepatitis, problems with bowel movements, rectal bleeding or other intestinal problem	○ Yes	○ No	11	Operation or serious injury	○ Yes	○ No
6	Sugar, protein or blood in urine or other bladder or kidney problem	○ Yes	○ No	12	Hay fever, hives or other allergy	○ Yes	○ No
				13	Severe acne, eczema or other skin disorder	○ Yes	○ No
				14	Cancer or other tumor	○ Yes	○ No
				15	A disorder not listed above (specify)	○ Yes	○ No

Details: Identify questions by number and include diagnosis; age or dates; and treatment.

Section 4: Medical Health History

1	Depression	○ Yes	○ No	13	Panic disorder	○ Yes	○ No
2	Anxiety disorder	○ Yes	○ No	14	Learning disability	○ Yes	○ No
3	Eating disorder	○ Yes	○ No	15	Anti-social or conduct disorder	○ Yes	○ No
4	Bipolar disorder	○ Yes	○ No	16	Alcohol or substance abuse or dependence	○ Yes	○ No
5	Obsessive-compulsive disorder	○ Yes	○ No	17	Have you been hospitalized for a psychiatric disorder	○ Yes	○ No
6	Anger management issue	○ Yes	○ No				
7	PTSD	○ Yes	○ No	18	Have you been treated for alcohol and/or drug addiction?	○ Yes	○ No
8	ADD/ADHD	○ Yes	○ No				
9	Suicide attempt	○ Yes	○ No	19	Are you currently being treated by a psychologist, psychotherapist (counselor, psychologist, social worker) or other mental health professional?	○ Yes	○ No
10	Thoughts of suicide	○ Yes	○ No				
11	Self harm (e.g. cutting)	○ Yes	○ No				
12	Sleep disorder	○ Yes	○ No				

Details: Identify questions by number and include diagnosis; age or dates; and treatment.

Describe any medical or mental health problems or conditions that required psychological care.

Are you taking, or have you ever taken, medication for any of the above? Please list medication and dates.

Section 5: Medical Treatment Consent for Minors

A parent or guardian must sign if the student is under 18 years of age. In the event of serious illness or injury, every effort will be made to contact the parent or guardian.

I give permission for health care providers to administer any necessary medical or dental procedures to my child in the case of an emergency.

Parent signature Date

Student signature Date

Section 6: Disability Information

Accommodations are available upon request to those students entitled to them under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act. Students with medically documented disabilities requiring accommodations must first make a request by contacting the Student Disability Services Coordinator at 626 396-2323 to set up an appointment. Students are responsible for making their needs known in a timely fashion, and for providing current documentation for the review process.

Section 7: Verification

I certify that all information concerning my medical and/or psychological history is accurate and complete to the best of my knowledge.

Student signature Date