



INTERNATIONAL STUDENT (F-1) MEDICAL FORM

To the Student: Please take this form to your physician or clinic for completion. **Important:** The following sections must be completed before submitting this form to the International Office. Health forms lacking completion of these sections will not be considered valid. **Failure to submit a valid health form by the indicated deadline will result in your admission application being incomplete.** Students should make and retain a copy of their health forms for their personal records prior to submitting it to the College. A physician, physician assistant, or nurse practitioner must complete your physical exam.

REPORT OF MEDICAL HISTORY

(Please print in black Ink)

To be completed by student

Last Name:		First name		Middle Name	
Permanent Address:					
City:		State:		Zip:	
Area Code/Phone Number:					
Date of Birth (mm/day/yr):		/ /		Gender (Circle):	
				Male Female	
Marital Status (Circle):					
Single		Married		Other	
Previously enrolled here (Circle):					
Yes		No		If yes, dates: _____	
Semester Entering (Circle):					
Fall		Summer		Spring YEAR: _____	
Hospital/Health Insurance (Name and Address of Company):					
Area Code/Phone Number:					
Name of Policy Holder:			Employer:		
Policy or Certificate Number: _____			Group Number: _____		
Is this an HMO/PPO/Managed Care Plan?					
		Yes		No	
Name of person to contact in case of an emergency:					
Relationship:			Area Code/Phone Number:		
Address:		City:		State: Zip Code:	

The following health history is confidential, except in an emergency situation or by court order, will not be released without your written permission. Your health history does not affect your admission status. Please attach additional sheets for any items that require fuller explanation.

PERSONAL HEALTH HISTORY

Please answer all questions, indicate comments on all positive answers on a separate paper.

HAVE YOU HAD	YES	NO		YES	NO		YES	NO		YES	NO
Eye Trouble			Frequent or Severe Respiratory Infections			Kidney or Bladder Disease			Diseases ↓		
Ear, Nose, Throat Trouble			Rheumatic Fever or Heart Mummer			Disease or injury of Bones or Joints			Infectious		
Frequent or Severe Headache			Stomach or Intestinal Trouble			“Tick” Knee, Shoulder, etc.			Female Only: ↓		
Epilepsy			Hepatitis or Jaundice			Anemia			Irregular Periods		
Asthma, High Fever									Severe Cramps		
Tuberculosis									Extensive Flow		

	YES	NO	Explanation
Do you have any conditions or disabilities that limit your physical activities? (If yes, please describe)			
Have you ever been a patient in any type of hospital? (Specify when, where, and why.)			
Has your academic career been interrupted due to physical or emotional problems? (Please explain)			
Is there loss or seriously impaired function of any paired organs? (Please describe.)			
Other than for a routine check-up, have you seen a physician or health-care professional in the past six months? (Please describe.)			
Have you ever had any serious illness or injuries other than those already noted? (Specify when and where and give details.)			

Important Information: Please read and complete statements by student or parent/guardian (If student under age 18): I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless otherwise permitted by law. If I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the institution to release information from my (son/daughter’s) medical record to a physician, hospital, or other medical professional involved in providing me (him/her) with emergency treatment and/or medical care.

Signature of Student	Date:
Signature of Parent/Guadian	Date:

(If student under age 18)

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