WRIGHT STATE UNIVERSITY
STUDENT HEALTH SERVICES
051 STUDENT UNION
3640 COLONEL GLENN HWY
DAYTON, OH 45435
PHONE # (937) 775-2552
FAX # (937) 775-3260

T0: INCOMING FI AND JI INTERNATIONAL STUDENTS

FROM: STUDENT HEALTH SERVICES

SUBJECT: MEDICAL HISTORY FORM AND POLICY ON IMMUNIZATIONS AND TUBERCULOSIS SCREENING

This is to inform you that WRIGHT STATE UNIVERSITY has a POLICY ON IMMUNIZATIONS AND TUBERCULOSIS SCREENING

WRITTEN DOCUMENTS WITH COMPLETE DATES (IN ENGLISH) ARE REQUIRED FOR ALL IMMUNIZATIONS AND THE SCREENING

REQUIRED IMMUNIZATIONS ARE:

1. TETANUS/DIPTHERIA (TETANUS, TD, DT, TDAP) Booster within the last ten (10) years

2. MMR (Measles, Mumps, Rubella) – TWO (2) DOSES-THE FIRST AFTER AGE ONE (1) YEAR, THE SECOND DOSE AT LEAST THIRTY (30) DAYS AFTER THE FIRST INJECTION

3. A negative Tuberculin MANTOUX skin test (TB/PPD), OR a negative CHEST X-RAY REPORT from a chest x-ray performed within the past 12 months. THE MANTOUX TUBERCULIN TEST MUST INCLUDE THE DATE OF THE INJECTION, THE DATE IT WAS “READ” BY A LICENSED PROFESSIONAL BETWEEN 48 AND 72 HOURS AFTER IT WAS ADMINISTERED, AND THE RESULTS OF THE TEST IN MILLIMETERS (MM). The tuberculin screening is required to be repeated EVERY YEAR.
   If a student has a POSITIVE screening result (10mm or greater) they MUST have a chest x-ray, and a copy of the written report (in English) is required. A new chest x-ray is required every year,
   UNLESS:
   Documentation is provided of nine (9) months of INH antibiotic therapy
   OR:
   Documentation is provided of A NEGATIVE QUANTIFERON report

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WRIGHT STATE UNIVERSITY
MEDICAL HISTORY FORM
INTERNATIONAL STUDENTS
(FI AND JI VISA)

DATE: ____________________

UID#: __________________

(Print)
NAME ____
LAST NAME FIRST NAME MIDDLE NAME

ADDRESS ____
STREET OR P O BOX CITY STATE ZIP

DATE OF BIRTH ______________________ PLACE OF BIRTH ______________________

GENDER MALE ________ FEMALE _________

LOCAL HOME PHONE NUMBER ______________________ CELL PHONE NUMBER ______________________

PERSON TO NOTIFY IN AN EMERGENCY ______________________ THEIR PHONE # ______________________

INSURANCE WAIVER (FROM UCIE) NO __________________ YES ___________________

ALLERGIES TO MEDICATION ______________________ TO FOOD ______________________

CURRENT MEDICATIONS (INCLUDING DOSAGE) ____

____

Have you ever had, or do you currently have, any of the following?

	Yes	No		Yes	No		Yes	No
1. Anemia or other blood disease			**5. Diabetes**			**9. Rheumatic Fever**		
2. Asthma			**6. Heart disease**			**10. Seizures**		
3. Bone or joint disease			**7. Kidney disease**			**11. Other (please specify)**		
4. Chickenpox			**8. Lung disease**					

REQUIRED IMMUNIZATIONS - (WRITTEN DOCUMENTS REQUIRED-IN ENGLISH)

TETANUS (TETANUS, TD, DT, TDAP)
WITHIN THE PAST TEN YEARS

_______/__________/__________
MONTH DAY YEAR

MMR (Measles, Mumps, Rubella)
TWO (2) DOSES AFTER AGE ONE (1) YEAR
AND MINIMUM 30 DAYS APART

_______/________/________ _______/________/________
MONTH DAY YEAR MONTH DAY YEAR

TUBERCULOSIS SCREENING (REQUIRED WITHIN LAST 12 MONTHS, REGARDLESS OF PAST BCG)
MUST BE DONE ACCORDING TO WSU REQUIREMENTS (SEE COVER LETTER FOR DETAILS)
***IF POSITIVE (10 MM OR MORE), COPY OF CHEST XRAY REPORT (IN ENGLISH) REQUIRED**

DATE GIVEN ______/______/______ **DATE READ** ______/______/______ **RESULTS (IN MM)** ________

TREATED WITH INH (ANTI-TUBERCULOSIS) DRUG? NO _______ YES ________ IF YES, HOW LONG? _____

NEGATIVE QUANTIFERON REPORT? NO ___ YES ___ IF YES, COPY OF LAB REPORT (IN ENGLISH) REQUIRED

RECOMMENDED IMMUNIZATIONS -

HEPATITIS B (Three doses of vaccine, or Positive Hep B Surface Antibody)

Dose #1 _____/_____/_____ Dose #2 _____/_____/_____ Dose #3 _____/_____/_____
MM DD YY MM DD YY MM DD YY

Hepatitis B Surface Antibody Date __________ Results ___________

MENNINGITIS VACCINE Date __________

SIGNATURE AND CONSENT

(IF STUDENT IS UNDER 18 YEARS OF AGE, BOTH STUDENT AND PARENT MUST SIGN)

I certify that the medical facts stated above are true to the best of my knowledge. I hereby consent to the performance of diagnostic procedures, including x-ray and laboratory tests, pelvic examinations, and the administration of treatments or medications that any physician or dentist associated with or consulted by Student Health Services deems necessary, and I agree to pay any charges for services not covered by university fees or by insurance.

I hereby consent to the release of medical information to the appropriate university representatives.

Signature of student Date

Signature of parent or legal guardian if student is under 18 Date