TO: Incoming F1 and J1 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/Diphtheria (Tetanus, TD, DT, TDAP) - Booster within the past 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) within the past twelve (12) months – The Mantoux Tuberculin Test must include the date of the injection, the date it was “read” by a licensed professional (must be “read” within 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 the student has a positive screening result (10 mm or greater), a chest x-ray, and a copy of the written report (in English) is required.

   UNLESS:

   Documentation is provided of nine (9) months of INH antibiotic therapy, OR:

   Documentation is provided of a negative Quantiferon report.
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 PO 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) ________________________________

___________________________ ________________

__________________________________________

__________________________________________

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

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<tbody>
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<td>1. Anemia or other blood disease</td>
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<td>7. Kidney disease</td>
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<td>10. Seizures</td>
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<td>11. Other (please specify)</td>
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REQUIRED IMMUNIZATIONS - (WRITTEN DOCUMENTS REQUIRED-IN ENGLISH)

TETANUS (TETANUS, TD, DT, TDAP) ____________________________
WITHIN THE PAST TEN YEARS __________/________/________

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

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