

STUDENT HEALTH SERVICES
 051 STUDENT UNION
 3640 COLONEL GLENN HWY
 DAYTON, OH 45435
 PHONE (937) 775-2552
 FAX (937)775-2277

**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) _____

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**

Wright State University
Student Health Services
051 Student Union
3640 Colonel Glenn Hwy
Dayton, OH 45435
Phone # (937) 775-2552
Fax # (937) 775-2277

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.