# 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**

**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 _____

MENINGITIS VACCINE Dose #1 ____/____/____
MM DD YY

Dose #2 (over age 16) ____/____/____
MM DD YY

## 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

Wright State University
3640 Colonel Glenn Hwy
Dayton, OH 45435

TO: Incoming F1 and J1 International Students

FROM: Wright State University

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.