INTERNATIONAL STUDENT MEDICAL HISTORY

STUDENT INFORMATION

Last name:	First:	Middle:	Preferred Name:		
Marital status? Single Married Divorced Widowed	Citizenship:	Birth date:	Age:	Sex: M F	
Street address:	City:	Phone Number: ( )			
P.O. box:	Country:	State:	Postal Code:		

Year you will begin your studies _____ What term are you applying for? Fall (August) Spring (January)

What program will you be entering? ESL Undergraduate Graduate

MEDICAL HISTORY

Do you have any special needs that we should be aware of?	❑ Visual	❑ Hearing	❑ Physical	❑ Learning Disability
Please check if you have had or have any of the following:	❑ Allergies ❑ Asthma ❑ Diabetes ❑ Dietary Problems ❑ Epilepsy/ Convulsive Disorder ❑ Kidney Stones/Infection ❑ Heart Problems ❑Hypertension ❑ Injuries ❑ Emotional/Mental Problems			

Your Physicians Name:	Physicians Phone:

Please list any medications you are currently taking:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

IN CASE OF EMERGENCY

Name of primary contact :	Relationship to you:	Phone: ( )
Name of secondary contact:	Relationship to you:	Phone: ( )

I authorize Campbellsville University to contact the above named individual(s) in the event of an emergency concerning me and/or any members of my immediate family.

_____ _____

Student signature *Date*

CONSENT OF EMERGENCY CARE

I do hereby give and grant to Campbellsville University and its Professional Staff, my consent to perform necessary emergency care procedures. They may use their judgment in securing medical aid and/or emergency transportation. I give and grant to any medical doctor or hospital my consent and authorization to render such aid, treatment, or care as in the judgment of said doctor or hospital, which may be required as an emergency basis, in the event I should be injured or stricken ill while under supervision of Campbellsville University personnel.

_____ _____

Student Signature Date

_____ _____

Parent/Guardian Signature (Required if student is under 18 years of age) Date

Tuberculosis (TB) Screening Questionnaire

Please answer the following questions:

Have you ever had a positive TB skin test? Yes No

Have you ever had close contact with anyone who was sick with TB? Yes No

Were you born in one of the countries listed below and arrived in the U.S. within the past 5 years? Yes No

If yes, please list the country _____

Have you ever lived in or traveled to/in one or more of the countries listed below? Yes No

If yes, please list the countries: _____

Countries with Estimated or Reported High Tuberculosis Incidence

Afghanistan Algeria Angola Anguilla Argentina Armenia Azerbaijan Bahamas Bahrain Bangladesh Belarus Belize Benin Bhutan Bolivia Bosnia & Herzegovina Botswana Brazil Brunei Darussalam	Bulgaria Burkina Faso Burundi Cambodia Cameroon Cape Verde Central African Rep. Chad China Colombia Comoros Congo Congo DR Cote d'Ivoire Croatia Djibouti Dominican Republic Ecuador Egypt	El Salvador Equatorial Guinea Eritrea Estonia Ethiopia Fiji French Polynesia Gabon Gambia Georgia Ghana Guam Guatemala Guinea Guinea-Bissau Guyana Haiti Honduras India	Indonesia Iran Iraq Japan Kazakhstan Kenya Kiribati Korea-DPR Korea-Republic Kuwait Kyrgyzstan Lao PDR Latvia Lesotho Liberia Lithuania Macedonia-TFYR Madagascar Malawi Malaysia	Maldives Mali Marshall Islands Mauritania Mauritius Mexico Micronesia Moldova-Rep. Mongolia Montenegro Morocco Mozambique Myanmar Namibia Nauru Nepal New Caledonia Nicaragua Niger Nigeria	Niue N. Mariana Islands Pakistan Palau Panama Papua New Guinea Paraguay Peru Philippines Poland Portugal Qatar Romania Russian Federation Rwanda St. Vincent & The Grenadines	Sao Tome & Principe Saudi Arabia Senegal Seychelles Sierra Leone Singapore Solomon Islands Somalia South Africa Spain Sri Lanka Sudan Suriname Syrian Arab Republic Swaziland Tajikistan Tanzania-UR Thailand Timor-Leste	Togo Tokelau Tonga Tunisia Turkey Turkmenistan Tuvalu Uganda Ukraine Uruguay Uzbekistan Vanuatu Venezuela Viet Nam Wallis & Futuna Islands W. Bank & Gaza Strip Yemen Zambia Zimbabwe

Tuberculosis Testing Record

If you have answered YES to any of the above questions, a PPD (Mantoux) skin test is required, even if you have had the BCG vaccination in the past. If you arrive to campus without having received a TB test you will be required to take the test in Campbellsville and cover all expenses related to the test. This test will not be covered by the CU provided medical insurance.

Your Health Care Provider must complete and sign below as proof of test:

TB (PPD) Skin Test	**Skin Test Result** (size of induration)	**Chest X-Ray** Required if TB skin test is Positive	**Health Care Provider**
Date Administered: _____ Date Test Read: _____	_____ Mm _____ Signature of Health Care Provider	_____ Date of X-ray Result: NEG POS (attach copy of written report)	_____ Signature _____ **Treatment** (if any)

REQUIRED VACCINES

MMR Vaccination* (measles, mumps, and rubella combined) If before 1970, please have the vaccine repeated before entering the university.	Date of 1st shot:	Date of 2nd shot:
Tetanus Shot* If longer than 10 years, please update tetanus before entering the university.	Date of last shot:	
Meningitis Vaccine (recommended but not required)	**Hepatitis B Vaccine** (recommended but not required)	

*A photocopy of immunization records MUST be included. Campbellsville University recommends that students get the meningitis vaccine from their personal physician or local health department.