UNIVERSITY of MONTEVALLO

International Student's Medical History

This medical history form is required of all NEW international students and must be returned prior to enrollment. All information must be less than 12 months old. All information is considered confidential.

***FULL NAME*: _____**

***STUDENT ID (M#):* _____**

Date of Birth: _____

Address: _____

_____

Phone/Cell Number: _____

Parent/Guardian: _____

Phone/Cell Number: _____

ALSO REQUIRED (Attach to this form):

1. **Tuberculosis (TB) Testing**
   Must be done within 12 months of class start date. Please include dates that the test was given and read. Results should be recorded in millimeters. If TB test unavailable, please provide blood assay (i.e., Q-Gold or T-Spot).
2. **Proof of #2 MMR vaccinations**
   Must submit a **COPY** of your immunization record, indicating #2 dates of MMR (measles, mumps, rubella) vaccines. If record not available, submit results of a rubeola titer.

START DATE AT UM:

Year: _____
☐ Fall Term ☐ Spring Term ☐ May Term
☐ Summer I (June) ☐ Summer II (July)

HEALTH INSURANCE:

UM requires international students to have a health insurance policy that meets US federal law requirements [refer to document 22 CFR 62.14]. You will be automatically enrolled in UM's plan unless you provide a copy of your own comparable coverage (translated to English) and complete a waiver (see link below for form).
http://www.montevallo.edu/assets/2013/08/International-Student-Health-Insurance-Waiver.pdf

FOR MORE HEALTH INSURANCE INFO:

http://www.montevallo.edu/admissions/international-admissions/health-insurance/

STRONGLY RECOMMENDED VACCINES:

Hepatitis B; Meningitis; Td/Tdap
Varicella (Chicken Pox); Flu (seasonal)

STUDENT AUTHORIZATION:

- I hereby affirm that all information supplied is complete and accurate to the best of my knowledge.
- I understand that I am responsible for my own physical and mental health, and for informing staff of any need for treatment. I understand that the University of Montevallo is not responsible for chronic illnesses which are a part of the medical history of the student.
- I hereby grant permission to Student Health Services to render medical care that in their judgment is deemed advisable, to make necessary referrals, to release medical information necessary for appropriate care and treatment, and to authorize hospitalization when recommended in the event of illness or accident, including any necessary transportation of student for such care. Parents, guardians, or next of kin will be promptly notified in the event of serious illness or accident, except when delay by such communication would endanger life.
- I hereby assume responsibility for any costs for medical care beyond that provided by Student Health Services or that which is covered by the semester health fee.

Student Signature: _____ **Date:** _____

Parent/Guardian signature, if student under 18 years. Must have signature before services can be rendered.

International Student's Medical History
PHYSICIAN ASSESSMENT OF STUDENT

FULL NAME: _____ *STUDENT ID (M#):* _____

STUDENT MEDICAL HISTORY

Circle if student has or has had any of the following:

Anemia	**Headaches**	**Seizures**	**Diabetes**
Blood disorder	**Depression**	**Assistive device**	**Thyroid disorder**
Asthma	**Anxiety**	**Stomach issues**	**Kidney/Urinary issue**
Allergies	**Mental illness**	**Heart condition**	**Hepatitis**
Sinus issues	**ADD/ADHD**	**High Blood Pressure**	**Tuberculosis**

OTHER: _____

CURRENT MEDICATIONS: _____

MEDICATION ALLERGIES: _____

PHYSICAL EXAM FINDINGS

Height: _____ **Weight:** _____ **BP:** _____ **Pulse:** _____ **RR:** _____

HEENT: _____

Heart: _____

Lungs: _____

Abdomen: _____

Neuro: _____

Ortho: _____

Derm: _____

Other pertinent findings: _____

Do you believe the student is physically and emotionally able to participate in a full program of college-level study and related activities? _____ Yes _____ No

If no, please explain: _____

PLEASE ATTACH TB TEST RESULTS AND PROOF OF #2 MMRS (see page 1 of 2)*

Physician Signature: _____ **Date:** _____

Office address/phone: _____