International Student Health Form
Medaille College Student Health Services

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Medaille College requires that each student submit the International Student Health Form completed in English to the Medaille College Health Office before admission to the College.

Last Name:____________________ First Name:____________________ M.I.:__________

Birthdate: __________/__________/__________ Gender:__________ ID number: ____________________
Month Day Year Male or Female

Permanent Address: ____
Number and Street

____
City or Town Country Postal Code Citizenship

Phone Number:____________________ Email:____________________

Emergency Contact Name:____________________ Relationship to Student: ____________________

Emergency Contact Phone Number: ____________________

Consent of parent or guardian for treatment of those under 18 years of age

To be completed if the student is under 18 years of age at the time of arrival on campus even if student will turn 18 during the academic year.

To obtain care that may be necessary for our students and to protect the physicians and institutions involved, it is necessary that you sign the consent for treatment statement. While every reasonable effort is made to contact families in the event of serious illness or injury, this is not always possible within a short period of time; therefore, the consent form is necessary to provide appropriate care.

Signature of Parent/Guardian indicates that Medaille College Student Health Services has permission to treat your child. This includes care and treatment by medical providers at any outside health care facility if deemed necessary by Medaille College Student Health Services.

____
Parent/Guardian Signature Date

HEALTH HISTORY

Drug Allergies:____

Current Medications & Doses:____

Medical/Psychological Conditions:____

____

____

IMMUNIZATION HISTORY

Student's name (please print): ____
Last First MI

Birthdate: ___________/__________/___________
Month Day Year

REQUIRED FOR ALL STUDENTS

This information must be completed and signed by your health care provider and submitted to the Medaille College Health Office before entering the College.

MMR (Measles, Mumps, Rubella)

Proof required if born on or after January 1, 1957.

Vaccination	Vaccine Date (Month/Day/Year)	Or Serology Results/Date
2 MMR's (combo measles, mumps & rubella vaccine) 1st dose after 1st birthday; 2nd dose at least 28 days later. **(OR list individual vaccines below)**	#1 #2	
2 MEASLES 1st dose after 1st birthday; 2nd dose at least 28 days later	#1 #2	_____/_____/_____ mm dd yy **IMMUNE** **NOT IMMUNE** (Please circle result) Attach lab results &/or note if immune
1 MUMPS after 1st birthday		_____/_____/_____ mm dd yy **IMMUNE** **NOT IMMUNE** (Please circle result) Attach lab results &/or note if immune
1 RUBELLA after 1st birthday		_____/_____/_____ mm dd yy **IMMUNE** **NOT IMMUNE** (Please circle result) Attach lab results &/or note if immune

RECOMMENDED: **MENINGOCOCCAL VACCINE** Must be within the past 5 years

***** (Student may decline meningococcal vaccination by completing meningitis response below) *****

Meningococcal Vaccine within the past 5 years _______/_______/_______
mm dd yy

[Note: The Advisory Committee on Immunization Practices recommends that all first-year college students up to age 21 years should have at least 1 dose of Meningococcal ACWY vaccine not more than 5 years before enrollment, preferably on or after their 16th birthday, and that young adults aged 16 through 23 years may choose to receive the Meningococcal B vaccine series. College and university students should discuss the Meningococcal B vaccine with a healthcare provider.]

PROVIDER INFORMATION REQUIRED

____ _________________________________

Signature of health care provider Date

____ _________________________________

Stamp of health care provider Phone number of practice

***** IMPORTANT—THIS MENINGITIS RESPONSE IS REQUIRED FOR ALL STUDENTS NOT VACCINATED IN THE PAST 5 YEARS *****

While you are not required to receive this vaccine, we strongly urge you to read the full information regarding meningitis at: http://www.medaille.edu/mngdisease

☐ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I (my child) will **not** obtain immunization against meningococcal meningitis disease.

____ _______________

Signature of student if 18 years of age or older or parent/guardian if student is under 18 years of age **Date**

MANDATORY TUBERCULOSIS SCREENING FORM

Student's name (please print): ____
Last First MI

Country of Birth: ______________________ Year arrived in US: __________________

SECTION A: TUBERCULOSIS (TB) EXPOSURE RISK QUESTIONAIRE

1. Have you or a close contact ever been sick with tuberculosis? YES NO
2. Have you ever had a positive mantoux test? [A mantoux (PPD) is a skin test for tuberculosis] YES NO
3. Have you ever been vaccinated with BCG? YES NO
4. Were you born in, or have you lived, worked or visited for more than one month in any of the following: Asia, Africa, South America, Mexico, Central America or Eastern Europe? YES NO
5. Have you had HIV/AIDS, diabetes, leukemia, lymphoma, head, neck, or lung cancer, chronic renal failure, illicit drug use, intestinal bypass, gastrectomy, chronic malabsorption syndrome, low body weight, prolonged corticosteroid therapy, an organ transplant, or a chronic immune disorder? YES NO
6. Do you have a persistent cough? (3 weeks or more), fever, night sweats, fatigue, loss of appetite, or weight loss? YES NO
7. Have you ever lived, worked, or volunteered in any homeless shelter, prison/jail, hospital or drug rehabilitation unit, nursing home or residential healthcare facility? YES NO

SECTION B: ATTENTION HEALTH CARE PROVIDER:

If student answers YES to any of the above questions, proof of the interferon gamma release assay (IGRA) or PPD is REQUIRED. If IGRA or PPD results are positive or student has a history of a positive PPD, a chest x-ray is REQUIRED. IGRA or PPD and/or chest x-ray must be done within six months prior to attendance. History of BCG vaccination does not prevent testing of a member of a high risk group.

PPD: Date placed ______________________ Date read ____________________ mm induration ______________________
(record actual mm of induration, transverse diameter: if no induration, write "0"

Interpretation: Positive_______ (chest x-ray required) Negative_______
(based on mm of induration as well as risk factors)*

OR

IGRA: Date obtained__________________ Negative_______ Positive_______

Chest X-ray: (Required if PPD or IGRA is positive) Date of chest x-ray ________________ Normal_______ Abnormal_______

Treatment Plan (include plan for TB prophylaxis treatment) ____

***Interpretation Guidelines for PPD**

>5mm is positive:
- Recent close contact of an individual with infectious TB
- Persons with fibrotic changes on a prior chest x-ray consistent with past TB disease
- Organ transplant recipients
- Immunosuppressed persons taking >15mg/d of prednisone for >1 month; taking a TNF-a antagonist
- Persons with HIV/AIDS

>10 mm is positive:
- Persons who were born or lived in a high prevalence country
- History of illicit drug use
- Mycobacteriology laboratory personnel
- History of residence, working, or volunteering in high-risk congregate settings
- Persons with the following clinical conditions: silicosis, diabetes, chronic renal failure leukemia, lymphoma, head, neck, or lung cancer, low body weight, gastrectomy or intestinal bypass, chronic malabsorption syndromes

>15 mm is positive:
- Persons with no known risk factors for TB disease

PROVIDER INFORMATION REQUIRED

____ ____________________________
Signature of health care provider Date

____ ____________________________
Stamp of health care provider Phone number of practice