International Student Health Information Form

Student name:	Student ID#

REQUIRED IMMUNIZATION FORM

✓ **International students: A photocopy of immunization records or clinic stamp/provider signature MUST be included.**

✓ **2 doses of Measles, Mumps and Rubella (MMR) vaccination are REQUIRED**

✓ **Meningococcal (MCV4) REQUIRED of all students under the age of 21**

REQUIRED VACCINES- MMR and Meningococcal (MCV4)

OFFICIAL DOCUMENTATION MUST BE ATTACHED

Meningococcal (MCV4) most recent dose: / /

MMR: (measles, mumps and rubella combined) 2 doses required

Dose 1_____/_____/_____ Dose 2_____/_____/_____
Month Day Year Month Day Year

Lab tests (titers) may be substituted as proof of immunity in lieu of vaccinations.
COPIES OF LAB WORK MUST BE ATTACHED ☐ I have attached a copy of my titer results

Health Care Provider Signature and Address: Signature/stamp of authorized health care official required here only if photocopies not provided.

RECOMMENDED VACCINES: please provide dates for these immunizations if they are available

Polio Date series completed (final dose given) ____/____/____

Hepatitis A
Dose 1____/____/____ Dose 2____/____/____

Hepatitis B
Dose 1____/____/____ Dose 2____/____/____ Dose 3____/____/____

Twinrix (Hepatitis A and Hepatitis B combined)
Dose 1____/____/____ Dose 2____/____/____ Dose 3____/____/____

Varicella (Chicken Pox)
Dose 1____/____/____ Dose 2____/____/____ OR date of disease____/____/____

Tetanus-Diphtheria (Td)
Date childhood series completed: ____/____/____ most recent booster____/____/____

Tetanus Diphtheria Pertussis (Tdap) Dose 1____/____/____

HPV Dose 1____/____/____ Dose 2____/____/____ Dose 3____/____/____

TB Screening _____ Result _____

Exemptions:

☐ I was born before January 1, 1957 (automatic exemption from MMR requirement, though a completed health form is still required).

☐ Medical waiver requested: you must come to Student Health Services to sign a waiver with a SHS clinician in order to receive a waiver.

Classical Christian School
for the Arts
4981 78th Ave North
Pinellas Park, FL 33781

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Which term are you beginning school?	**STUDENT ID#**
Name Last First Middle	**Country of Citizenship** ☐ **USA** ☐ **other country, specify:**_____ ☐ **US Resident Alien Card#** _____
By what name do you wish to be addressed?	**Date of Birth:** **Race:** ☐ **male** ☐ **female**
Permanent address	**Whom should we contact in an emergency?** **Name** **Relationship**
City State Zip	**Address**
Primary phone number	**City State Zip**
Secondary phone number	**Area code Phone (home)**
Email address	**Area code Phone (work)**

MEDICAL HISTORY: Do you have a present or past history of: (check all that apply)

1-HEAD/NEUROLOGICAL
- ☐ Cerebral palsy
- ☐ Head injury/concussion
- ☐ Migraine headaches
- ☐ Multiple sclerosis
- ☐ Recurrent headaches
- ☐ Seizures
- ☐ Other _____

2-EYES
- ☐ Blindness
- ☐ Eye trauma
- ☐ Other _____

3-EAR, NOSE & THROAT
- ☐ Hearing loss
- ☐ Recurrent ear infections
- ☐ Recurrent nose bleeds
- ☐ Recurrent sinus infections
- ☐ Recurrent strep throat
- ☐ Recurrent tonsillitis
- ☐ Seasonal allergies
- ☐ TMJ problems
- ☐ Other _____

4-LUNGS
- ☐ Asthma
- ☐ Exercise induced asthma
- ☐ Narcolepsy
- ☐ Pneumonia
- ☐ Recurrent bronchitis
- ☐ Sleep apnea
- ☐ Other _____

5-INFECTIONS
- ☐ Chicken pox
- ☐ Chlamydia
- ☐ Cold sores
- ☐ Genital herpes (HSV)
- ☐ Genital warts (HPV)
- ☐ Gonorrhea
- ☐ Hepatitis A
- ☐ Herpes zoster/shingles
- ☐ History of tuberculosis
- ☐ Lyme disease
- ☐ Malaria
- ☐ Meningitis
- ☐ Mononucleosis
- ☐ Positive TB skin test
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Other _____

6-CARDIO VASCULAR
- ☐ Congenital heart defect
- ☐ Heart attack
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Palpitations/Arrythmia
- ☐ Stroke
- ☐ Other _____

7-GYNECOLOGY
- ☐ Abnormal PAP tests
- ☐ Breast cancer
- ☐ Breast lump
- ☐ Cervical cancer
- ☐ Endometriosis
- ☐ Menstrual irregularities
- ☐ Ovarian cysts
- ☐ Pelvic Infection (PID)
- ☐ Pregnancy
- ☐ Recurrent vaginal infections
- ☐ Other _____

8-GENITOURINARY
- ☐ Chronic kidney disease
- ☐ Impotence
- ☐ Kidney infections
- ☐ Kidney stones
- ☐ Recurrent bladder infections
- ☐ Testicular cancer
- ☐ Other _____

9-MUSCULOSKELETAL
- ☐ Arthritis
- ☐ Bone fracture
- ☐ Carpal tunnel syndrome
- ☐ Chronic joint injury
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Herniated disk
- ☐ Recurrent ankle sprains
- ☐ Recurrent back pain
- ☐ Recurrent tendonitis
- ☐ Scoliosis
- ☐ Stress fracture
- ☐ Other _____

10-GASTROINTESTINAL
- ☐ Celiac disease
- ☐ Constipation
- ☐ Crohn's disease
- ☐ Gall bladder disease
- ☐ Hemorrhoids
- ☐ Irritable bowel syndrome
- ☐ Lactose intolerant
- ☐ Liver disease
- ☐ Recurrent heartburn/GERD
- ☐ Ulcer
- ☐ Ulcerative colitis
- ☐ Other _____

11-ENDOCRINE
- ☐ Diabetes type I
- ☐ Diabetes type II
- ☐ Hyper- (overactive) thyroid
- ☐ Hypo- (low) thyroid
- ☐ Metabolic syndrome
- ☐ Obesity
- ☐ Polycystic ovarian disease
- ☐ Thyroid cancer
- ☐ Thyroid nodule
- ☐ Other _____

12-MENTAL HEALTH
- ☐ Abuse or domestic violence
- ☐ ADHD / ADD
- ☐ Alcoholism or alcohol abuse
- ☐ Anorexia
- ☐ Anxiety
- ☐ Bipolar disorder
- ☐ Bulimia
- ☐ Depression
- ☐ Drug addiction or abuse
- ☐ Insomnia
- ☐ Learning disability
- ☐ Obsessive compulsive disorder
- ☐ Panic attacks
- ☐ Post traumatic stress disorder
- ☐ Schizophrenia
- ☐ Sexual assault
- ☐ Social anxiety
- ☐ Other _____

13-BLOOD DISORDER / CANCER
- ☐ Anemia
- ☐ Blood transfusions
- ☐ Cancer
- ☐ Clotting disorder
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Sickle cell disease
- ☐ Thalassemia
- ☐ Other _____

14-IMMUNE SYSTEM DISEASE
- ☐ Lupus
- ☐ Rheumatoid arthritis
- ☐ HIV / AIDS
- ☐ Ankylosing spondylitis
- ☐ Other _____

15-DERMATOLOGY
- ☐ Acne
- ☐ Eczema
- ☐ Precancerous mole
- ☐ Psoriasis
- ☐ Recurrent hives
- ☐ Skin cancer
- ☐ Other _____

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SOCIAL HISTORY

Do you now use any of the following?
- ☐ Tobacco
- ☐ Marijuana
- ☐ Other recreational drugs
- ☐ Stimulants (non-medical use)
- ☐ Other prescription drugs (non-medical use)

How often do you consume alcohol?
- ☐ Never
- ☐ Monthly or less
- ☐ 2 to 4 times a month
- ☐ 2 to 3 times a week
- ☐ 4 or more times a week

When you drink alcohol, how much do you typically drink in one day?
- ☐ None
- ☐ 1-2 alcoholic beverages
- ☐ 3-4
- ☐ 5-6
- ☐ 7-9
- ☐ 10 or more

SPECIAL NEEDS

Do you have any special needs that we should be aware of as we support your wellbeing at OSU?

☐ Visual ☐ Hearing ☐ Physical ☐ Learning disability ☐ Translator (language_____)

FAMILY HISTORY

Has any close relative (parents, siblings, grandparents, aunts, uncles) ever had any of the following?

- ☐ I am adopted (history unknown)
- ☐ Alcoholism
- ☐ Asthma
- ☐ Anemia
- ☐ Blood clots
- ☐ Breast cancer
- ☐ Cancer (other)
- ☐ Colon cancer
- ☐ Psychological disorder
- ☐ Diabetes
- ☐ Drug addiction
- ☐ Heart disease/heart attack
- ☐ High blood pressure
- ☐ Hereditary disease
- ☐ High cholesterol
- ☐ Kidney disease
- ☐ Melanoma
- ☐ Mental health problems (other)
- ☐ Ovarian cancer
- ☐ Phlebitis
- ☐ Stroke
- ☐ Suicide
- ☐ Thyroid disorder
- ☐ Tuberculosis

SURGICAL/HOSPITALIZATION/ALLERGY HISTORY

Please list your surgical history: (please enter none if you have not had any surgeries in the past)

Surgery (i.e.; appendectomy, pinning of fracture, etc.)	Date

Please list any hospitalizations not included in surgical history: (please enter none if you have never been hospitalized)

Hospitalization (i.e.; emergency room, overnight stay, etc.)	Date

Please list your allergy information: (please enter none if you have no known allergies)

Allergic to (include drug and non-drug allergies)	Type of reaction (rash, hives, stomach upset, etc.)