INTERNATIONAL STUDENT HEALTH HISTORY FORM

In order to enroll in classes at Lock Haven University, you must complete the Health History Form. This provides doctors/nurses with information should you need medical treatment. Please complete all sections of this form. You will need to have a physical check-up by a licensed doctor/nurse/physician. Please make sure the doctor/nurse/physician fills out the appropriate page and signs it. Please send the completed Health History Form to the Institute for International Studies with your completed application.

Part 1: Personal information to be completed by the student. Please type this information.

Part 2: Personal health history to be completed by the student. Please type this information.

Part 3: Physical examination to be completed by a licensed doctor/nurse/physician and signed.

Part 4: Required immunizations/vaccines to be completed by student or doctor/nurse/physician.

Part 5: Required tuberculosis information to be completed by student or doctor/nurse/physician.

Part 1: Personal information completed by the student.

I am an (select one): ___Exchange Student ___Matriculating Full-Time Student

Semester of Study: FALL 20___ Spring 20___ OR ACADEMIC YEAR 20___ TO 20___

Surname:	First Name, Middle Initial:	
Home Address:	City:	
State/Country:	Postal Code:	Phone Number:
Date of Birth: (Month/Day/Year)	Male ☐	Female ☐
Name of Emergency Contact:	Phone Number (include country code):	
Relationship to Student:	Emergency Contact's Email Address:	

Consent/Authorization for Treatment: I certify that the information provided on this Medical Health Form is true and complete to the best of my knowledge. I also realize that this information is confidential and for use by the Heath Service staff. I give permission for myself to be evaluated, diagnosed, and treated by Lock Haven University Health Services under the direction of a nurse. It should be understood that under certain circumstances, or emergencies, I may be referred to an area hospital, diagnostic testing facility, or medical specialist for evaluation, diagnosis, and/or treatment. I understand that any costs for these services are assumed by me and/or my insurance carrier.

Student Signature:	Date:

Family Name: _____ First Name: _____ Date of Birth: (___/___/___)
M D Y

Part 2: Personal health history completed by the student. Please complete all questions								
Allergies:			Medications:					
Have you ever had:	Yes	No	Have you ever had:	Yes	No	Have you ever had:	Yes	No
Hepatitis A,B or C			Asthma			Attention Deficit Disorder/ ADHD		
HIV			Pneumonia			Bipolar Disorder		
Mononucleosis			Sinusitis			Depression		
Chicken Pox			Seasonal Allergies			Anxiety		
Measles (Rubeola)			Shortness of Breath			Panic Attacks		
Mumps			Unexplained Fainting			Suicide Attempts		
German Measles (Rubella)			Thyroid Disease			Learning Disability		
Tuberculosis			Diabetes			Eating Disorder		
Rheumatic/Scarlet Fever			Hypoglycemia			Psychiatric problems		
Gallbladder Disease			Arthritis			Alcohol/Drug Dependency		
Gastroesophageal Reflux Disease (GERD)			Back Problems			**Female**		
Liver Disease			Headaches			Ovarian Cysts		
			Concussion Dates:					
Polyps (Colon)			Seizure Disorder			Breast Disease		
Heart Disease, Murmur, or Infection			Cancer			Past Pregnancy		
High/Low Blood Pressure			Tumor/Cyst			Irregular Periods		
Chest Pain/Discomfort			Anemia			Excessive Cramping		
Eye Disorders/Disease			Physical Disabilities			**Male**		
Ear Disorders/Disease			**Any Surgeries** Describe:			Hernia		
Dental Disorders			Broken Bones			Testicular Problems		

Family Name: _____ First Name: _____ Date of Birth: (___/___/___)
M D Y

Part 3: Physical examination to be completed by a licensed doctor/nurse/physician & signed.			
Medical Evaluation	Normal	Abnormal Findings Explained	Initials
BP:____/____			
Height: Weight:			
Head, Face, Neck, and Scalp			
Eyes (acuity) and Ophthalmic Exam			
Ear, Nose, Throat, Sinuses, Mouth			
Lungs and Chest			
Heart			
Abdomen			
Skin			
Neurological			
G-U			
Menstrual History (if applicable)			
Musculoskeletal			
Neck			
Back/shoulder/arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			
REQUIRED FOR ATHLETES			
Heart Murmur			
Femoral Pulses to Exclude Aortic Corarctation			
Physical Stigmata			
Brachial Artery BP Sitting		Left: Right:	

Doctor/Physician Information (MUST BE COMPLETE)

Doctor/Physician Signature:	Date: (M/D/Y)	Print Name:
Address:		City/Providence:
State/Country:	Postal Code:	Phone Number:

MANDATORY FOR ATHLETES ONLY

Medically cleared for intercollegiate athletics and sports ☐ Yes ☐ No	Doctor/Physician Signature:	Date: (M/D/Y)

Family Name: _____ First Name: _____ Date of Birth: (___/___/___)

M D Y

Part 4: Required immunizations/vaccines to be completed by the student or licensed doctor/nurse/physician.

				M / D / Y
Tdap (Tetanus Diphtheria Pertussis) (1 shot within the last 10 years)				___/___/___
Meningitis (1 shot within the last 5 years)				___/___/___
MMR (Measles, Mumps, Rubella) (2 shots)			___/___/___	___/___/___
Varicella (Chicken Pox) (2 shots **OR** age at time of disease)		Age:	___/___/___	___/___/___
Hepatitis B (3 shots)		___/___/___	___/___/___	___/___/___
Polio (IPV) (4 shots)	___/___/___	___/___/___	___/___/___	___/___/___
	M / D / Y	M / D / Y	M / D / Y	M / D / Y

Part 5: Required tuberculosis information to be completed by student or licensed doctor/nurse/physician.

Please answer the following questions:

Have you ever had close contact with persons known or suspected to have active TB disease? **Yes** **No**

Were you born in one of the countries listed below that have a high incidence of active TB disease? **Yes** **No** **(If yes, CIRCLE country)**

Afghanistan	Comoros	Iraq	Namibia	Somalia
Algeria	Congo	Japan	Nepal	South Africa
Angola	Cote d'Ivoire	Kazakhstan	Nicaragua	Sri Lanka
Argentina	Demo. Rep. of Korea	Kenya	Niger	Sudan
Armenia	Demo. Rep. of Congo	Kiribati	Nigeria	Suriname
Azerbaijan	Djibouti	Kuwait	Pakistan	Swaziland
Bahrain	Dominican Republic	Kyrgyzstan	Palau	Syrian Arab Republic
Bangladesh	Ecuador	Lao Demo. Rep.	Panama	Tajikistan
Belarus	El Salvador	Latvia	Papua New Guinea	Thailand
Belize	Equatorial Guinea	Lesotho	Paraguay	Former Yugoslav Rep. of Macedonia
Benin	Eritrea	Liberia	Peru	Timor-Leste
Bhutan	Estonia	Libyan Arab Jamahiriya	Philippines	Togo
Bolivia	Ethiopia	Lithuania	Poland	Tunisia
Bosnia & Herzegovina	Fiji	Madagascar	Portugal	Turkey
Botswana	Gabon	Malawi	Qatar	Turkmenistan
Brazil	Gambia	Malaysia	Rep. of Korea	Tuvalu
Brunei Darussalam	Georgia	Maldives	Rep. of Moldova	Uganda
Bulgaria	Ghana	Mali	Romania	Ukraine
Burkina Faso	Guam	Marshall Islands	Russian Fed.	United Rep. of Tanzania
Burundi	Guatemala	Mauritania	Rwanda	Uruguay
Cambodia	Guinea	Mauritius	St. Vincent and the Grenadines	Uzbekistan
Cameron	Guinea-Bissau	Mexico	Sao Tome and Principe	Vanuatu
Cape Verde	Guyana	Micronesia	Senegal	Venezuela
Central African Rep.	Haiti	Mongolia	Seychelles	Vietnam
Chad	Honduras	Morocco	Sierra Leone	Yemen
China	India	Mozambique	Singapore	Zambia
Colombia	Indonesia	Myanmar	Solomon Islands	Zimbabwe

Family Name: _____ First Name: _____ Date of Birth: (___/___/___)

M D Y

Part 5: Continued required tuberculosis information

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2010. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to http://apps.who.int/ghodata

Have you had frequent or prolonged visits* to one or more of the countries listed above with a high prevalence of TB disease? (If yes, CHECK the countries, above) **Yes** **No**

Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? **Yes** **No**

Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease?

Yes **No**

Have you ever been a member of any of the following groups that may have an increased incidence of latent *M. tuberculosis* infection or active TB disease – medically underserved, low-income, or abusing drugs or alcohol? **Yes** **No**

If the answer is YES to any of the above questions, Lock Haven University requires that you receive TB testing as soon as possible but at least prior to the start of the subsequent semester).

If the answer to all of the above questions is NO, no further testing or further action is required.
** The significance of the travel exposure should be discussed with a health care provider and evaluated.*

TUBERCULOSIS (TB) RISK ASSESSMENT (to be completed by nurse/physician/doctor provider)

Clinicians should review and verify the information above. Persons answering YES to any of the questions in Part K are candidates for either
Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented.

History of a positive TB skin test or IGRA blood test? (If yes, document below) **Yes** **No**

History of BCG vaccination? (If yes, consider IGRA if possible.) **Yes** **No**

1. TB Symptom Check
Does the student have signs or symptoms of active pulmonary tuberculosis disease? Yes No
If No, proceed to 2 or 3
If yes, check below:
____ Cough (especially if lasting for 3 weeks or longer) with or without sputum production
____ Coughing up blood (hemoptysis)
____ Chest pain
____ Loss of appetite
____ Unexplained weight loss
____ Night sweats
____ Fever
Proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum
evaluation as indicated.

2. Tuberculin Skin Test (TST)
(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0".
The TST interpretation should be based on mm of induration as well as risk factors.)**

Date Given: M____/D____/Y_____ Date Read: M____/D____/Y_____
Results: _____mm of induration Interpretation: ____positive
____negative

Family Name: _____ First Name: _____ Date of Birth: (___/___/___)
M D Y

****Interpretation guidelines**

>5 mm is positive:

- Recent close contacts of an individual with infectious TB
- Persons with fibrotic changes on a prior chest x-ray, consistent with past TB disease
- Organ transplant recipients and other immunosuppressed persons (including receiving equivalent of >15 mg/d of prednisone for >1 month.)
- HIV-infected persons

>10 mm is positive:

- recent arrivals to the U.S. (<5 years) from high prevalence areas or who resided in one for a significant* amount of time
- injection drug users
- mycobacteriology laboratory personnel
- residents, employees, or volunteers in high-risk congregate settings
- persons with medical conditions that increase the risk of progression to TB disease including silicosis, diabetes mellitus, chronic renal failure, certain types of cancer (leukemias and lymphomas, cancers of the head, neck, or lung), gastrectomy or jejunoileal bypass and weight loss of at least 10% below ideal body weight.

>15 mm is positive:

- persons with no known risk factors for TB who, except for certain testing programs required by law or regulation, would otherwise not be tested.

** The significance of the travel exposure should be discussed with a health care provider and evaluated.*

Management of Positive TST or IGRA

All students with a positive TST or IGRA with no signs of active disease on chest x-ray should receive a recommendation to be treated for latent TB with appropriate medication. However, students in the following groups are at increased risk of progression from LTBI to TB disease and should be prioritized to begin treatment as soon as possible.

- Infected with HIV
- Recently infected with *M. tuberculosis* (within the past 2 years)
- History of untreated or inadequately treated TB disease, including persons with fibrotic changes on chest radiograph consistent with prior TB disease
- Receiving immunosuppressive therapy such as tumor necrosis factor-alpha (TNF) antagonists, systemic corticosteroids equivalent to/greater than 15 mg of prednisone per day, or immunosuppressive drug therapy following organ transplantation
- Diagnosed with silicosis, diabetes mellitus, chronic renal failure, leukemia, or cancer of the head, neck, or lung
- Have had a gastrectomy or jejunoileal bypass
- Weigh less than 90% of their ideal body weight
- Cigarette smokers and persons who abuse drugs and/or alcohol

•Populations defined locally as having an increased incidence of disease due to *M. tuberculosis*, including medically underserved, low-income populations

_____Student agrees to receive treatment
_____Student declines treatment at this time

After your health history from has been signed and completed by you and a licensed doctor/nurse/physician, please submit documents to:

Lock Haven University
Glennon Health Services
401 North Fairview Street
Lock Haven, PA 17745

Phone: +1- 570-484-2276
Fax: +1-570-484-2522
Email: studenthealthservices@lockhaven.edu

Please Note: Please keep a copy of this form, and any attachments, for your records

Family Name: _____ First Name: _____ Date of Birth: (___/___/___)
M D Y