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 dated within last 12 months. All information is considered confidential.

START DATE AT UM: Year: _____ ___Fall ___Spring ___Summer

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

Date of Birth: _____ Phone Number: _____

Address: _____

Emergency Contact: _____ Phone Number: _____

REQUIRED (Please submit the following with this 2 page form):

1. **Tuberculosis (TB) Testing:** Must be done within 12 months of class start date. Please include dates of both test administration and results. Results should be recorded in millimeters. If TB skin 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 blood titer.

HEALTH INSURANCE REQUIRED:

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 policy unless you provide a copy of your own comparable coverage (translated to English) and complete a waiver. For UM's current policy information and to print a copy of the waiver, please visit: https://www.montevallo.edu/admissions-aid/international-admissions/health-insurance/

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 UM 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 student fees.

Student Signature: _____ Date: _____

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

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PHYSICIAN ASSESSMENT OF STUDENT

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

STUDENT MEDICAL HISTORY *Circle if student has or has had any of the following:*

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

Physician Signature: _____ **Date:** _____

Office contact info: _____

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