

# MID-CONTINENT UNIVERSITY

## INTERNATIONAL STUDENT STATEMENT OF HEALTH

Student's Name: \_\_\_\_\_

Country of Residence: \_\_\_\_\_ Additional countries lived in: \_\_\_\_\_

***This form must be completed by attending physician who is not related to student.***

Has the applicant ever had any of the following:

Any disease, impairment or abnormality of:

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Drugs	<input type="checkbox"/>	<input type="checkbox"/>	Measles (Rubella)	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Organ/Digestive System
<input type="checkbox"/>	<input type="checkbox"/>	Food Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Bones, Joints, Locomotor System
<input type="checkbox"/>	<input type="checkbox"/>	Smoke Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Blood, Endocrine System
<input type="checkbox"/>	<input type="checkbox"/>	Pet Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Rubella	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Brain, Nervous System
<input type="checkbox"/>	<input type="checkbox"/>	Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	Ears or Hearing
<input type="checkbox"/>	<input type="checkbox"/>	Cough (persistent, recurring)	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	Eyes or Vision
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Genito-Urinary System
<input type="checkbox"/>	<input type="checkbox"/>	Enuresis	<input type="checkbox"/>	<input type="checkbox"/>	Malaria	<input type="checkbox"/>	<input type="checkbox"/>	Heart or Blood Vessels
<input type="checkbox"/>	<input type="checkbox"/>	Goiter (Struma)	<input type="checkbox"/>	<input type="checkbox"/>	Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Lungs, Respiratory System
<input type="checkbox"/>	<input type="checkbox"/>	Headache (persistent, recurring)	<input type="checkbox"/>	<input type="checkbox"/>	Sleepwalking	<input type="checkbox"/>	<input type="checkbox"/>	Skin (Acne, etc)
<input type="checkbox"/>	<input type="checkbox"/>	Learning or Speech Defect	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	TBC - Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Parasites (intestinal, other)	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo, Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Tonsils, Nose or Throat

If "Yes" was checked for any of the above the physician must provide full details and dates of treatment.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has student ever been hospitalized?  Yes  No If Yes, please provide details and dates: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Is applicant presently taking any medication or injections?  Yes  No If Yes, please list: \_\_\_\_\_

\_\_\_\_\_

Has applicant ever consulted a psychologist, psychiatrist, neurologist or any other specialist for any of the following disorders:

\_\_\_\_ Nervous or Emotional disorder                      \_\_\_\_ Sexual abuse  
\_\_\_\_ Eating disorder (anorexia nervosa, bulimia, etc.)                      \_\_\_\_ Emotional or physical abuse

If any were checked please explain: \_\_\_\_\_

\_\_\_\_\_

Please provide the following information:

Blood Type \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Are there any restrictions on the student's participation in physical and/or sports activities?  Yes  No

If Yes, explain limitations: \_\_\_\_\_

**IMMUNIZATION RECORD**

All students must provide proof of the following Immunizations:

VACCINE	Dates each dose was given (month/day/year)				
	1st Dose	2nd Dose	3rd Dose	4th Dose	5th Dose
Polio (TOPV)					
DPT and/or TD (diphtheria - tetanus - pertussis whooping cough and/or tetanus and diphtheria only)					
*MMR (measles, mumps, rubella)					
Hepatitis B					
Hepatitis A (not required)					
Meningitis (not required)					
<p>*If this immunization has not been given then give dates student may have had these diseases:                      Measles: _____ Mumps: _____ Rubella: _____</p>					

*If available, please attach a complete copy of your immunization records.*

Your opinion of the state of the candidate's health:  Excellent  Good  Fair  Poor

Comments on health: \_\_\_\_\_  
 \_\_\_\_\_

I, the undersigned, have received the medical history of the applicant and given a thorough physical examination and certify that all important medical information has been noted on this form and that nothing relevant has been omitted.

\_\_\_\_\_  
 Physician' signature

\_\_\_\_\_  
 Printed name

\_\_\_\_\_  
 Address

\_\_\_\_\_  
 Date