INTERNATIONAL (F-1) STUDENT MEDICAL HISTORY

To the Student: Please take this form to your physician or clinic for completion.
Important: The following sections must be completed before submitting this form to Craven Community College Admissions Office. Health forms lacking completion of these sections will not be considered valid. **Failure to submit a valid health form by the indicated deadline will result in your admission application being incomplete.** Students should make and retain a copy of their medical history form for their personal records prior to submitting it to the College. A physician, physician assistant, or nurse practitioner must complete your physical examination.

REPORT OF MEDICAL HISTORY
To be completed by student (Please print in black ink)

Last Name (print) First Name Middle Name

U.S.A. Mailing Address Street City State Zip Code Area Code/Phone Number

Date of Birth (MM/DD/YY) ______________ Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Other

Previously enrolled at Craven? ☐ Yes ☐ No

If yes, dates ______________________ Initial Start Semester: ☐ Fall 201_ ☐ Spring 201_ ☐ Summer 201_

Medical Insurance (Name and Address of Company) Area Code/Phone Number

Name of Policy Holder Policy Holder's Employer

Is this an HMO/PPO/Managed Care Plan? ☐ Yes ☐ No

Policy or Certificate Number Group Number

Name of person to contact in case of an emergency Relationship to Student

Address City State Zip Code Country Area Code/Phone Number

The following health history is confidential and, except in an emergency situation or by court order, will not be released without your written permission.
Your health history does not affect your admission status. Please attach addition sheets for any items that require fuller explanation.

PERSONAL HEALTH HISTORY

Please answer all questions, indicate comments on all positive answers on a separate paper.

HAVE YOU HAD	Yes	No	HAVE YOU HAD	Yes	No	HAVE YOU HAD	Yes	No	HAVE YOU HAD	Yes	No
Eye Trouble			Hepatitis or Jaundice			Asthma, High Fever			Tuberculosis		
Ear, Nose, Throat Trouble			Rheumatic Fever or Heart Murmur			Disease or injury of Bones or Joints			Frequent or Sever Headaches		
Stomach or Intestinal Trouble			"Trick" Knee, Shoulder, etc.			Epilepsy			Anemia		
Diabetes			Infectious Diseases (List)								

	Yes	No	Explanation
Do you have any conditions or disabilities that limit your physical activities? (If yes, please describe)			
Have you ever been a patient in any type of hospital? (Specify when, where, and why)			
Has your academic career been interrupted due to a physical or emotional problem? (Please explain)			
Is there lost or seriously impaired function on any paired organs? (Please describe)			
Other than for a routine check-up, have you seen a physician or healthcare professional in the past 6 months? (If yes, why)			
Have you ever had any serious illness or injuries other than those already noted? (Specify when, where. Give details.			

Important Information…Please read and complete statements by student (or parent/guardian if student under age 18):

I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless otherwise permitted by law. If I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the institution to release information from my (son/daughter's) medical record to a physician, hospital, or other medical professional involved in providing me (him/her) with emergency treatment and/or medical care.

Signature of Student ______________________________ Date ______________

Signature of Parent/Guardian ______________________________ Date ______________
(If student under age 18)

Physical Examination (required)
To be completed and signed by physician or clinic (Please print in black ink.)

Last Name | First Name | Middle Name | Date of Birth

Mailing Address | City | State | Zip Code | Area Code/Phone Number

Height __________ Weight __________ BP____/____ Pulse__________/minute

Visions: Corrected Right 20/______ Left 20/_______ Hearing (gross) Right __________

Uncorrected Right 20/______ Left 20/_______ Left __________

Urinalysis

Sugar __________
Albumin __________
Micro __________

Hematocrit

________%

Are there abnormalities?	Normal	Abnormal
Head, Ears, Nose, Throat		
Eyes		
Respiratory		
Cardiovascular		
Hernia		
Genitourinary		
Musculoskeletal		
Metabolic/Endocrine		
Neuropsychiatric		
Skin		
Mammary		

IMMUNIZATIONS	mm/dd/yy #1	mm/dd/yy #2	mm/dd/yy #3	mm/dd/yy #4
DTP or Td (within 10 years)				
Td or Tetanus Booster				
Polio, oral				
MMR (after 1st birthday)				
Measles (after 1st birthday)				
Mumps				
Rubella				
BCG Vaccine				
Please note: **IF YOU HAVE NOT HAD THE BCG VACCINE, A TB test is required and must be administered within the last 12 months.** Tuberculin (PPD) Test Date Read (within 12 months) mm induration				
Chest X-ray If positive PPD Date Results				
Treatment, if applicable Date				

A. Is there loss or seriously impaired functions of any paired organs? ☐ Yes ☐ No
Explain ____________________

B. Is student under treatment for any medical or emotional condition? ☐ Yes ☐ No
Explain ____________________

C. Recommendation for physical activity (physical education, sports, etc.) ☐ Unlimited ☐ Limited
Explain ____________________

D. Is student physically and emotionally healthy? ☐ Yes ☐ No
Explain ____________________

Signature or Clinic Stamp REQUIRED:

Signature of Physician/Physician Assistant/Nurse Practitioner | **Date of Examination**

Print Name of Physician/Physician Assistant/Nurse Practitioner | **(Area Code) Phone Number**

Office Address | **City** | **State** | **Zip Code**