Benedict College

Office of International Programs

INTERNATIONAL STUDENT HEALTH FORM

This form must be completed as instructed below and submitted to the Office of International Programs in order to complete the initial admissions process.

- 1. Parental Consent to be signed by parent, if the student is under 18 years of age.
- 2. Personal Information to be completed by the student.
- 3. Emergency Contact Information to be completed by the student
- 4. Medical history (tuberculosis screening, and immunization history) to be completed by health care provider.

1. The Parental Consent section is to be filled and signed by the parent **ONLY** if student is under 18 years of age.

I hereby authorize any medical treatment and/or counseling services for my son☐ daughter☐

(Name)_____that may be advised or recommended by the healthcare providers and/or counselors at Benedict College.

Parent Signature_____ Date_____

2. PERSONAL INFORMATION (Write your name exactly as it appears in your passport).

Last (Surname) _____First _____ Middle (if any)_____

Date of birth: Month_____Day_____Year_____ Male ☐Female ☐

Legal Address: House number and street name _____

City_____State/province_____Country_____

Phone (include country code) +_____ Email:_____

Applying for (check one) ☐ Fall (August admission) ☐ Spring (January admission) Year 201__

Student's Signature: _____ Date _____

3. Emergency Contact Information

Last Name (Surname)_____**First Name** _____**Middle**_____

Phone: (Include Country Code) +_____ Email: _____

Relationship to you:_____

4. MEDICAL HISTORY (To be completed by the student's health care provider/person completing the form)

This form will become part of the student's medical record, therefore, accurate health information is essential for Health Services at the College to be able to provide the student with the best possible care. Medical information is confidential and will not be released to anyone apart from Benedict College Health Services without the student's or parent's permission, except as required by law, such as with court-order release or in reporting

certain communicable diseases to the Department of Public Health. Please be sure to forward any medical records that will help us care for you to the Office of International Programs.

List any major conditions, surgeries, or hospitalizations

Have you ever had or have you ever been diagnosed with any of the following (Please check all that apply).

	Allergy to latex		High blood pressure		Cancer (specify):
	Anemia		High cholesterol		
	Anorexia nervosa		HIV infection		
	Anxiety disorder		Inflammatory bowel disease		Food allergy, serious (specify):
	Arthritis		Colitis		
	Asthma		Crohn's Disease		
	Attention deficit disorder		Learning disability		Heart/vascular problems:
	Bleeding disorder		Loss of consciousness		Aneurysm
	Blood clots, deep vein		Malaria		Angina
	Bulimia		Menstrual problems		Congestive heart failure
	Chicken pox		Migraine		Heart attack (myocardial infarction)
	Chronic fatigue syndrome		Mononucleosis		Stroke
	Chronic lung disease		Overweight/obesity		Kidney disease
	Concussion		Parasitic disease		Sexually transmitted disease (specify)
	Depression		Pelvic inflammatory disease		
	Diabetes mellitus		Prostatitis		
	Eating disorder		Repetitive stress injury		Skin problems, current (specify)
	Endometriosis		Seizure		
	Hay fever/allergic rhinitis		Smoker, packs per day _____		
	Head injury, serious		Tuberculosis		Sleep disorder/insomnia
	Headaches, severe, non migraine		Broken bones (specify):		Thyroid disorder
	Heart murmur				Tuberculosis exposure
	Hepatitis B		Eye problems, serious (specify):		Treatment:
	Hepatitis C				Weight gain or loss, recent

Use this space to provide more details about anything you have checked off above:

_____

_____

Are you allergic to, or have you had any bad reactions to any medications? Yes □ No □

Medication_____

Type of reaction_____

Family History

Name	Relationship to you	Alive (A) Deceased (D)	Chronic Illnesses	If deceased, cause of death

4. TUBERCULOSIS (TB) RISK ASSESSMENT AND OTHER DESEASES/CONDITIONS

1. Recent close contact with someone with infectious TB disease □ Yes □ No

2. Abnormal prior chest x-ray suggesting inactive or past TB disease □ Yes □ No

3. HIV/AIDS □ Yes □ No Organ transplant recipient □ Yes □ 4. History of illicit drug use □ Yes □ No
4. Resident, employee or volunteer in a high-risk congregate setting (correctional facilities, nursing home, homeless shelters, hospitals or other healthcare facilities) □ Yes □ No
5. Medical condition associated with increased risk of progression to TB disease if infected (diabetes Mellitus, silicosis, head, neck or lung cancer, hematologic or reticuloendothelial disease such as Hodgkin's disease or leukemia, end stage renal disease, intestinal bypass or gastrostomy, chronic Malabsorption syndrome, low body weight, 10% or more below ideal for the given population □ Yes □ No

IF YES TO ANY QUESTION ABOVE, TB TESTING IS REQUIRED.

HEALTHCARE PROVIDER: If student has signs or symptoms of active TB, he/she must be treated and cured of TB before he/she can enroll at Benedict College. A statement from the treating physician indicating treatment and cure is required. We will accept testing that has been done within the past 12 months.
Tuberculin Skin Test (TST) Results must 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: ____/____/_____ Date Read: ____/____/_____

Result: _____ mm induration Interpretation: Negative ____ Positive ____

Interferon Gamma Release Assay (IGRA): Check the specific method: □ QFT-G □ TSPOT □ other

Date Obtained: ____/____/_____ Result: □ Negative □ Positive □ Indeterminate

Chest x-ray: Required if TST or IGRA is positive, or symptoms of active disease present. Attach a copy of the chest x-ray report to this document. We will accept a chest x-ray performed within the last three months.

Date of chest x-ray: ____/____/_____ Result: □ Normal □ Abnormal

Sputum evaluation: Required if symptoms of active TB disease are present. Attach a copy of the sputum report to this document.

Date performed: ____/____/_____ Result: □ Normal □ Abnormal

If TB test was positive, was INH prophylaxis completed? If so, dates: ____/____/_____ until ____/____/_____

5. IMMUNIZATION RECORD. (Must be completed by your health care provider)
The State of South Carolina and Benedict College require that all full time students and all students on a visa be immunized against certain communicable diseases. All immunization dates must include, month, day, and year. To comply with this requirement, have this form completed and signed by your health care provider.

1. Hepatitis B Dose #1: ___/___/___ Dose #2: ___/___/___ Dose #3: ___/___/___

2. Diphtheria, pertussis, and Tetanus: (DPT)___/___/___ Td: ___/___/___

3. Measles-Mumps-Rubella (MMR): Dose #1: ___/___/___ Dose #2: ___/___/___

4. Menomune A/C/Y/W-135 Meningococcal Vaccine (Recommended by American College Health Association, ACHA)

Name of Health Care Provider/person who completed form: _____
Signature:_____

Phone:+_____ Date:_____

License No./seal