international student **medical form**

Developed by the Association of Christian Schools International (ACSI) for Christian Schools

Instructions

Please read all directions on each page carefully before completing this medical form. Use the checklist below to ensure that you have completed all sections appropriately and obtained all necessary signatures.

Medical Form Checklist

- ◯ **Medical Information** (includes student information, medical history, school immunization record, and physical examination)—to be completed by the student's physician in consultation with the student and signed and dated by the physician
- ◯ **Dental Information** (includes a dental exam)—to be completed by the student's dentist
- ◯ **Authorization for Medical Care and Release of Medical Records Liability**—to be read, signed, and dated by the student's physician, parents/legal guardians, and student (if of legal age)

Filling Out This Medical Form

Your medical form must be legible and written in English using proper grammar and spelling. Answer all questions completely; do not simply write "same" or "see above" or "see previous." Enter your information directly onto the medical form unless directed otherwise.

Whenever you are asked for your name, enter your name exactly as it appears on your passport or birth certificate. Write your full name at the top of all medical form pages.

All dates should be written in the following format: month / day / year.

Copies and Signatures

You will need to submit one copy of this form. (You may also wish to make a copy for your own records.)

Questions

If you have any questions about this medical form, check with the school directly.

Submitting the Medical Form

Submit your completed medical form directly to the international student program (ISP) coordinator at the school.

ISP Coordinator: Greg Clark, Superintendent

Phone: 314-972-6227

Address: 845 Dunn Rd. Florissant, MO 63031

Email: g.clark@nccsmo.org

Applicant's Name _____

medical **information**

Please type or print clearly.

Part I—Student Information (to be completed by student)

Student's Full Legal Name _____

Gender: ◯ Male ◯ Female Date of Birth (MONTH/DAY/YEAR) _____/_____/_____

Address—Street _____

City _____ State/Province _____ Postal Code _____ Country _____

Home Phone _____ Cell Phone _____

E-mail _____

Part II—Medical History (to be completed by physician/medical doctor in consultation with the student)

Important: *Physician, this student is considering a year abroad as an international student. Insufficient, inadequate, or improper information about medications or psychiatric, psychological, or other medical conditions could endanger the student's life while overseas. Allergy information is especially crucial to host family placement and student well-being. An immediate relative of the student may* ***not*** *complete the examination or fill out this form.*

1. How long has the student been a patient of yours? _____

2. Has the student ever been diagnosed with or received treatment, attention, or advice from a physician or other practitioner for the following allergies?:

A. Aspirin	◯ Yes	◯ No	D. Insect stings/bites	◯ Yes	◯ No	G. Other _____			
B. Food	◯ Yes	◯ No	E. Penicillin	◯ Yes	◯ No				
C. Hay fever	◯ Yes	◯ No	F. Poison ivy/oak/other	◯ Yes	◯ No	H. Does the student carry an epinephrine autoinjector (such as EpiPen)?	◯ Yes	◯ No	

For any *yes* answers, please explain—below or on a separate sheet of paper (numbered 2A)—the disorder's nature and severity, the diagnosis, the frequency of attacks, and the treatment dates and duration. (If you need to attach additional pages, include the student's full legal name and date of birth at the top of each page).

Applicant's Name _____

medical **information**

3. Has the student ever been diagnosed with or received treatment, attention, or advice from a physician or other practitioner for any disease, impairment, or abnormality of:

- Altitude sickness ○ Yes ○ No
- Allergies ○ Yes ○ No
- Anorexia/bulimia/other eating disorder ○ Yes ○ No
- Appendicitis ○ Yes ○ No
  Has the student's appendix been removed? ○ Yes ○ No
- Arthritis ○ Yes ○ No
- Asthma ○ Yes ○ No
- Autoimmune disease (any) ○ Yes ○ No
- Blood or endocrine system ○ Yes ○ No
- Bones, joints, or locomotion system ○ Yes ○ No
- Bowel problems ○ Yes ○ No
- Brain or nervous system ○ Yes ○ No
- Cancer ○ Yes ○ No
- Communicable disease (any) ○ Yes ○ No
- Depression ○ Yes ○ No
- Diabetes ○ Yes ○ No
- Ears or hearing ○ Yes ○ No
- Eyes or vision ○ Yes ○ No
  Does the student wear corrective eyeglasses/contact lenses? ○ Yes ○ No
- Epilepsy ○ Yes ○ No
- Genitourinary system ○ Yes ○ No
- Hearing loss ○ Yes ○ No
- Heart disease ○ Yes ○ No
- Heart or blood vessels ○ Yes ○ No
- Hernia ○ Yes ○ No
  Has the student ever been operated on for a hernia? ○ Yes ○ No
- Hypertension ○ Yes ○ No
- Liver disease/hepatitis ○ Yes ○ No
- Lungs, respiratory system ○ Yes ○ No
- Malaria ○ Yes ○ No
- Menstrual disorders ○ Yes ○ No
- Mental or emotional disorders ○ Yes ○ No
- Pneumonia ○ Yes ○ No
- Rheumatic fever ○ Yes ○ No
- Scarlet fever ○ Yes ○ No
- Seizures ○ Yes ○ No
- Serious headache/migraine ○ Yes ○ No
- Serious or persistent cough ○ Yes ○ No
- Skin ○ Yes ○ No
- Stomach or digestive system ○ Yes ○ No
- Stomach ulcer ○ Yes ○ No
- Tonsils, nose, or throat ○ Yes ○ No
  Have the student's tonsils been removed? ○ Yes ○ No
- Typhoid fever ○ Yes ○ No
- Urinary tract infection ○ Yes ○ No
- Vertigo/dizziness ○ Yes ○ No
- Other _____ ○ Yes ○ No

For any *yes* answers, please explain—below or on a separate sheet of paper (numbered 3A)—the disorder's nature and severity, the frequency of attacks, and the treatment dates and duration.

4. Has the student:

A. Had any surgical operation not covered in question 2 or 3 or been hospitalized or treated for any other condition not covered in question 2 or 3? ○ Yes ○ No

B. Taken any prescribed medication in the past six months? ○ Yes ○ No

C. Ever used heroin, cocaine, marijuana or other hallucinogens, amphetamines, or other street drugs? ○ Yes ○ No

D. Ever received treatment for or advice about a problem with alcohol or drug use, either from a physician or other practitioner or an organization that assists those who have an alcohol or drug problem? ○ Yes ○ No

E. Had excessive weight gain or loss recently? ○ Yes ○ No

F. Had any dietary restrictions for medical, religious, or personal reasons? ○ Yes ○ No

Applicant's Name _____

medical **information**

Please explain any *yes* answers below or on a separate sheet of paper (numbered 4A). (If you need to attach additional pages, include the student's full legal name and date of birth at the top of each page).

5. Will the student be bringing any prescribed medication to the host country? ◯ Yes ◯ No
   If yes, please list each medication, including the international and generic names, compound symbols, dosage, frequency, and reason for use:

Prescribed Medication	Dose/Frequency	Reason for Use
_____	_____	_____
_____	_____	_____

6. Indicate whether the student has had the following infectious diseases and the date(s) **(MONTH/DAY/YEAR)** the student had the disease(s):

Hepatitis A	◯ Yes, date(s): ____/____/_____	◯ No	Rubella (German/3-day measles)	◯ Yes, date(s): ____/____/_____	◯ No
Hepatitis B	◯ Yes, date(s): ____/____/_____	◯ No	Scarlet fever	◯ Yes, date(s): ____/____/_____	◯ No
Measles (rubeola/10-day red measles)	◯ Yes, date(s): ____/____/_____	◯ No	Tuberculosis	◯ Yes, date(s): ____/____/_____	◯ No
Mumps	◯ Yes, date(s): ____/____/_____	◯ No	Varicella (chicken pox)	◯ Yes, date(s): ____/____/_____	◯ No
Pertussis (whooping cough)	◯ Yes, date(s): ____/____/_____	◯ No	Other: _____	◯ Yes, date(s): ____/____/_____	◯ No

Part III—School Immunization Record (to be completed by physician/medical doctor)

Physician—*The student is required to be immunized for measles, mumps, and rubella (MMR) within the last 10 years to enter school in the United States and some other countries. Previous illness is not accepted as immunization in some schools. Additional immunizations may be necessary to meet state , provincial, and country requirements upon arrival. Please clearly state the dates of each immunization. The student has been immunized against the following diseases:*

Vaccine	Record date of each advised immunization (MONTH/DAY/YEAR)				
Hepatitis A	1st ____/____/_____	2nd ____/____/_____			
Hepatitis B	1st ____/____/_____	2nd ____/____/_____	3rd ____/____/_____		
DPT: Diphtheria	1st ____/____/_____	2nd ____/____/_____	3rd ____/____/_____	4th ____/____/_____	5th ____/____/_____
Pertussis (whooping cough)	1st ____/____/_____	2nd ____/____/_____	3rd ____/____/_____	4th ____/____/_____	5th ____/____/_____
Tetanus (within last 10 years)	1st ____/____/_____	2nd ____/____/_____	3rd ____/____/_____	4th ____/____/_____	5th ____/____/_____
MMR: Measles (rubeola/10-day red measles)	1st ____/____/_____	2nd ____/____/_____			
Mumps	1st ____/____/_____	2nd ____/____/_____			
Rubella (German/3-day measles)	1st ____/____/_____	2nd ____/____/_____			
Polio	1st ____/____/_____	2nd ____/____/_____	3rd ____/____/_____	4th ____/____/_____	
Varicella (chicken pox)	1st ____/____/_____				
Other (specify) _____	1st ____/____/_____	2nd ____/____/_____	3rd ____/____/_____	4th ____/____/_____	5th ____/____/_____

Additional comments:

The student must present evidence of recent (within 3 months) tuberculosis screening. Screening date: **(MONTH/DAY/YEAR)** ____/____/_____.

Mantoux tuberculin skin test result/diagnosis: _____ OR QuantiFERON®-TB Gold test result/diagnosis: _____

Was the student ever treated for tuberculosis? ◯ **Yes, date(s): (MONTH/DAY/YEAR)** ____/____/_____ ◯ No

If yes, please explain the treatment method: _____

Did the student ever receive a BCG vaccine? ◯ **Yes, date(s): (MONTH/DAY/YEAR)** ____/____/_____ ◯ No

Applicant's Name _____

medical **information**

PART IV—Physical Examination (to be completed by physician/medical doctor)

Age _____ Height: _____ Weight: _____ Blood Pressure: Sys _____ Dia _____ Pulse rate/minute: _____

Are reflexes normal for: Pupils ○ Yes ○ No Knees ○ Yes ○ No Other (please specify) _____ ○ Yes ○ No

Does today's examination show any abnormal findings for:

Head and neck	○ Yes	○ No	Lymph nodes/breasts	○ Yes	○ No	Abdomen (mass)	○ Yes	○ No
Ear, nose, throat	○ Yes	○ No	Genitalia	○ Yes	○ No	Rectal	○ Yes	○ No
Chest/lungs	○ Yes	○ No	Extremities (muscular)	○ Yes	○ No	Skin	○ Yes	○ No
Heart (murmur, pressure)	○ Yes	○ No	Skeletal system	○ Yes	○ No			
Hernias	○ Yes	○ No	Neurological	○ Yes	○ No			

Please explain any *yes* answers below or on a separate sheet of paper (numbered 5A). (If you need to attach additional pages, include the student's full legal name and date of birth at the top of each page).

Part V—Certification (to be completed by physician/medical doctor)

I certify that I hold a valid current license to practice medicine and am not an immediate relative of the patient. I certify that I have personally examined the student and reported my findings as noted in the Medical Information pages of this international student medical form and any attached page(s). I further state that all the information I have supplied is true and accurate to the best of my knowledge.

Check one:

○ I have attached _____ additional pages

○ I have not attached additional pages

Check one:

○ I find the student in good health and **not** suffering from any mental or medical condition(s) that would preclude studying in another country as an international student.

○ I find the student suffering from mental or medical condition(s), as noted in my report, that **would preclude studying** in another country as an international student.

Check one:

○ I find the student in good health and **not** suffering from any condition(s) that would preclude participation in sporting/physical activities.

○ I find the student suffering from a condition(s) as noted in my report that **would preclude participation** in sporting/physical activities.

Physician's Name (please print) _____

Signature _____ **Date** _____

Address—Street _____

City _____ State/Province _____ Postal Code _____ Country _____

Home Phone _____ Cell Phone _____

E-mail _____

Applicant's Name _____

dental **information**

Please type or print clearly.

Dentist: This student is considering studying abroad as an international student. Insufficient, inadequate, or improper information about the student's dental health, medications, or other problems could endanger this student while overseas. An immediate relative of the student may **not** complete the dental examination.

Student's Full Legal Name _____

Gender: ○ Male ○ Female Date of Birth (MONTH/DAY/YEAR) ___/___/_____

Address—Street _____

City _____ State/Province _____Postal Code _____Country_____

Home Phone _____ Cell Phone _____

E-mail _____

Dental Examination

1. Is the student in good dental health? ○ Yes ○ No

2. Does the student require dental work at this time? ○ Yes ○ No

3. Do you foresee the student requiring any dental work while abroad? ○ Yes ○ No

If you answered *yes* to question 3, please provide detailed information on a separate page ***(typed or computer-generated with the student's full legal name and date of birth at the top of each page)***.

I certify that I hold a valid current license to practice dentistry and am not an immediate relative of the patient. I certify that I have personally examined the student and reported my findings as noted above on the Dental Information page of this international student medical form and any attached page(s). I further state that all the information I have supplied is true and accurate to the best of my knowledge.

Check one:

○ I have attached _____ additional pages

○ I have not attached additional pages

Dentist's Name (please print) _____

Signature _____ **Date** _____

Address—Street _____

City _____ State/Province _____Postal Code _____ Country _____

Home Phone _____Cell Phone _____

E-mail _____

Applicant's Name _____

medical **release**

Authorization for Medical Care and Release of Medical Records and Liability

Please read carefully. Sign and date below where indicated.

I/We, the undersigned parent(s)/legal guardian(s) (hereafter *parents*) of the student, and I, the student, if of legal age, hereby authorize the release of medical and dental information in the International Student Medical Form acquired in the course of the examinations by the physician and the dentist. I/We, the parent(s), and the student, who have the sole and legal right to make the decisions on the health and care of the student, do release from liability and grant permission as noted of the following while he/she is overseas as an international student attending _____ (hereafter *school*):

- In the event of accident or sickness, I/we authorize any school staff and/or host parent(s) of the student to select the appropriate medical facility and physician(s)/dentist(s) to provide treatment.
- I/We hereby authorize and consent to any X-ray examination, administration of anesthetic, blood transfusion, surgical operation, or any other medical or surgical diagnosis and treatment rendered under the general or special supervision of any member of the medical staff and emergency-room staff licensed by the state of treatment and/or the provisions of the Medical Treatment Act, or a dentist licensed by the state of treatment and/or under the provisions of the Dental Treatment Act, or staff of any acute general hospital holding a current license to operate a hospital.
- I/We further consent to any medical or surgical treatment by a licensed physician, surgeon, or dentist that might be required by my/our son/daughter for any emergency situation. I/We do request that I/we be notified as soon as possible, but emergency treatment need not be delayed to provide such notice.
- Permission is granted for any additional immunizations that may be required per school and state regulations.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but it is given to provide authority and power to render care which the aforementioned physician or dentist in the exercise of his/her best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached. In the case of elective surgery, I/we request that I/we be notified and our permission obtained before such arrangements are made.

I/We agree to hold harmless and release from all liability the school and all staff or all members of the host family for any intervention in an emergency situation regardless of final outcome. I/We agree to assume all financial obligations beyond those covered by health, accident, and sickness insurance for any medical treatment rendered.

Father's/Legal Guardian's Name (please print) _____

Signature (mandatory if student is under age 18) _____ **Date** _____

Address—Street _____

City _____ State/Province _____ Postal Code _____ Country _____

Home Phone _____ Cell Phone _____ Work Phone _____

Mother's/Legal Guardian's Name (please print) _____

Signature (mandatory if student is under age 18) _____ **Date** _____

Address—Street _____

City _____ State/Province _____ Postal Code _____ Country _____

Home Phone _____ Cell Phone _____ Work Phone _____

Student's Name (please print) _____

Signature _____ **Date** _____

Witness' Name (please print) _____

Signature _____ **Date** _____