

INTERNATIONAL STUDENT MEDICAL HISTORY

This form may be completed on a computer or by hand, but must be printed and signed by hand before it is returned to Dallas Int'l's International Student Center. It becomes part of your Application paper work. Return by fax, air mail, or as a scanned pdf attached to an email. If scanned, bring the original copy with you when you come to the US.

Personal Information

First Semester of Enrollment: Fall Spring 20_____

_____ Male Female

Family/Surname First/given Middle

_____ Date of Birth ____/____/____
Month / Day / Year

Address _____

City _____ Province/State _____ Postal Code _____ Country _____

Home Phone: _____ Work phone: _____ Other: _____

Social Security number : _____ - _____ - _____

Marital Status: Single Married Divorced Widowed Citizenship: _____

Next of Kin: Spouse Parent(s) Guardian Other Name: _____

Address if different than above: _____

Home Phone: _____ Work phone: _____ Other: _____

Health Insurance Company _____ Policy Number _____

Medical Information

Please answer all questions. Comment on all positive answers using the next sheet with certifying signature.

- | | Yes | No |
|--|-----|----|
| A. Has your physical activity been restricted during the past five years?..... | | |
| B. Have you had difficulty with school, studies, or teachers?..... | | |
| C. Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem?..... | | |
| D. Have you had an illness or injury or been hospitalized other than those noted below?..... | | |
| E. Do you need to take any medication by prescription? If yes, list on next page..... | | |
| F. Are you currently taking any other medication? If yes, list on next page..... | | |
| G. Have you been rejected or discharged from military service because of a physical, emotional, or other reason? | | |
| H. Do you have any questions in regard to your health, family history, or other matters such as pre-marital counseling, which you would like to discuss with a member of the staff or CounselingCenter?..... | | |

I certify all questions have been answered correctly and completely. _____
Student's Signature

Have you ever had **Yes** **No**

01 Scarlet Fever.....

02 Measles.....

03 German Measles (Rubella).....

04 Mumps.....

05 Chicken Pox.....

06 Diabetes.....

07 Malaria.....

08 HIV (Tested Positive).....

09 Tuberculosis.....

10 Insomnia.....

11 Hepatitis.....

12 Frequent anxiety.....

13 Frequent depression.....

14 Worry or nervousness.....

15 Mental Illness.....

16 Recurrent colds.....

17 Head injury with unconsciousness.....

18 Epilepsy, convulsions.....

19 Asthma.....

20 Shortness of breath.....

21 Hay Fever.....

..... **Yes** **No**

22 Allergy.....

 a. Penicillin.....

 b. Sulfonamides.....

 c. Serum.....

 d. Foods.....

 e. Other.....

23 Dizziness, fainting.....

24 Chronic cough.....

25 Heart palpitations.....

26 Hearing impairment.....

27 Visual Impairment.....

28 High/low blood pressure.....

29 Rheumatic fever or heart murmur.....

30 Tumor, cancer, cyst.....

31 Chest pain/pressure.....

32 Weakness/paralysis.....

33 Venereal disease.....

34 Frequent urination.....

35 Severe cramps.....

36 Recent gain/loss of weight.....

37 Other _____

Please detail any positive answers from previous sections in the space below.

I certify all questions have been answered correctly and completely. _____
Student's Signature

Student Treatment Consent and Release

In case of illness or accident, I give Dallas International University and its representative(s) full permission to secure medical, dental, and/or surgical care that may include transportation to a doctor or hospital of their choice, injections, examination, medication, and surgery that is considered necessary for my good health. I agree to pay all medical costs and fees, including costs and fees for all emergency medical treatment and transportation. In all events, I understand and agree that Dallas Int'l does not have any liability or responsibility for any injury or damage that may arise from such medical, dental, and/or surgical care. In case of serious illness, I give Dallas Int'l and its representative(s) permission to contact next of kin listed on my medical history.

_____ **Student's Signature** **Date Signed**

Notice: Dallas Int'l has the option to require a check-up by a physician if one is indicated by information on this form.

Immunization Record

Please indicate if you have had these immunizations by giving the most recent vaccination date. Most are only recommended, but the Meningitis vaccine is required by Texas state law for students under 30 years old.

A. Meningitis – One of the following government approved vaccines is required by law for students under 30 years old.

Month/Year

Meningococcal Conjugate Vaccine (MCV4) /

OR

Meningococcal Polysaccharide Vaccine (MPSV4) /

B. Tetanus-Diphtheria

Completed primary series of tetanus-diphtheria immunization /

Received tetanus-diphtheria /

C. MMR (Measles, Mumps, and Rubella)

Dose 1 Immunized at 12 months or after and before five years of age /

Dose 2 Immunized after 1980 /

Measles (Rubeola) – if given instead of MMR, enter appropriate dates.

Had disease, confirmed by office report /

Born before January 1, 1960, and therefore considered immune..... /

Have report of immune titer (specific date of titer) /

Immunized with live measles vaccine after 1980 /

Mumps – if given instead of MMR, enter appropriate dates.

Serologic confirmation of mumps immunity..... /

Immunized with vaccine at 12 months after birth or later /

Rubella – if given instead of MMR, enter appropriate dates.

Serologic confirmation of rubella immunity..... /

Immunized with vaccine at 12 months after birth or later /

D. Polio

Completed primary series of polio immunization

Type of vaccine: Oral Inactivated E-IPV..... /

E. Chicken Pox

Type of vaccine _____ Dosage _____ /

F. Hepatitis

Hepatitis A

Hepatitis B

Dose 1 Date ____/____

Dose 1..... /

Dose 2 Date ____/____

Dose 2..... /

Dose 3 /

G. Fluzone (Flu-annually) /

I certify all questions have been answered correctly and completely. _____

Student's Signature

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Please return completed forms, signed on each page, to:

**Dallas International University
International Student Center
7500 W. Camp Wisdom Road
Dallas, TX 75236**

**Email: ISC@diu.edu
Telephone: (972) 708-7573
Fax: (972) 708-7396**