WESTLAKE CHRISTIAN ACADEMY

# Health Records for International Student

## Part I: Student Information

Student's Full Legal Name:_____
Last First Middle

Gender: _____Male _____Female Date of Birth:_____/_____/_____

Student's Home Address _____
Street/Building

_____
City State/Province Postal Code Country

_____ _____
Home Phone Parent Mobile Phone

## Part II: Medical History (to be completed by a physician in consultation with the student)

Important: Physician, this student is considering a year or more 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.

**Height:**_____ **Weight:**_____

1. How long has the student been your patient? _____
2. Has the student ever been diagnosed with or receive advice 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 | Yes | No | | |

If any of the answers above are "Yes," please explain the nature and security of the disorder, diagnosis, frequency of attacks, and treatment dates and duration (please attach additional pages if necessary):

_____

_____

_____

_____

_____

_____

_____

_____

_____

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## Part II: Medical History (Continued)

3. Has the student ever been diagnosed with or received treatment or advice for any disease or abnormality of any of the following? (Please circle if "Yes"):

a. Altitude sickness
b. Anorexia/eating disorder
c. Appendicitis
d. Arthritis
e. Asthma
f. Autoimmune disease
g. Blood or Endocrine system
h Bones/joints
i. Bowel problems
j. Brain/nervous system
k. Cancer
l. Communicable disease
m. Depression
n. Diabetes
o. Ears/hearing
p. Eyes/vision
q. Epilepsy
r. Genito-urinary system
s. Heart disease
t. Hernia
u. Hypertension
v. Liver/Hepatitis
w. Respiratory system
x. Malaria
y. Menstrual disorders
z. Mental/emotional disorders
aa. Pneumonia
bb. Scarlet fever
cc. Seizers
dd. Serious headache
ee. Serious/ persistent cough
ff. Skin
gg. Stomach/digestive system
hh. Tonsils, nose, or throat
ii. Typhoid fever
jj. Vertigo/dizziness
kk. Other

Please explain the nature and severity of disorder, diagnos, frequency of attacks, treatment dates, and duration of any circled answers (please attach additional pages if necessary):

_____

_____

_____

_____

_____

4. Has the student:

a. Had any surgical operation not revealed in question 2 or 3 or been hospitalized or Treated for any other condition not revealed in question 2 or 3? ___Yes ___No

b. Taken any prescribed medication in the past six months: ___Yes ___No

c. Even 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/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

g. Had any psychological problems? ___Yes ___No

h. Had any injury that would prevent them from participating in sports? ___Yes ___No

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Please explain any "Yes" answers below (please use additional paper if needed):

_____

_____

_____

_____

5. Will the student be bringing any prescribed medications to the host country? ___Yes ___No

If "Yes" please list each medication, including international and generic names, compound symbols, dosage/frequency, and reason for use.

| Prescription Medications | Dose/Frequency | Reason for Use |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

6. The student must present evidence of recent (within 3 months) screening:

Tuberculosis screening: Date: _____

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

_____

Has the student ever been treated for tuberculosis? ___Yes Date(s)_____ ___No

If "Yes," please explain the treatment method: _____

Has the student ever received a BCG vaccine? ___Yes Date(s)_____ ___No

Result of chest x-ray: _____Date_____
(mo/day/yr)

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 above. I further state that all the information I have supplied is true and accurate to the best of my knowledge.

Printed Name of Physician: _____

Physician's Signature: _____

Physician's Address _____

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