

International Office
 141 E. 12TH STREET
 P.O. Box 9000
 HOLLAND, MI 49422-9000
 Fax: 616-395-7937



Hope College Health Center
Health History Form
For our
International Students

I will be studying at Hope for (circle one): one semester one year 2-3 years 4 years
 Country I am arriving from: _____

Instructions: This form is a requirement for entry to Hope College and Treatment in the Health Center.

1. Complete top boxes. Submit a copy of your immunization record ...**OR**...have your health care provider complete immunization history form below. Refer to attached sheet for minimum immunization requirements.
2. Backside is to be completed **and signed** by the Hope student.
3. Return form by mail or fax to Hope International Office, at the above address, BEFORE January 9, 2012.

NOTE: All information is confidential and not part of academic records. The information is only accessible to the staff of the Health & Counseling Services, unless written authorization is provided in compliance with HIPAA

Last Name	First Name	Middle Initial	Age	Birthdate (month, date, year)	Female	Male
Permanet Home Address (Street, City, State/Province, Country)			Home Telephone with country or area codes			

Required Immunizations for Participation at Hope College

<u>Tetanus/Diphtheria/ Pertussis</u>	<u>Measles/ Mumps/ Rubella</u>	<u>Chickenpox (Varicella)</u>	<u>Hepatitis B</u>	<u>Polio</u>	<u>Meningococcal Conjugate (MCV4)</u>
Dates Tetanus received: _____ _____ _____	Dates Measles (Rubeola) Received: _____ _____	I had this disease at age _____ or year _____	Dose # 1 _____ Dose # 2 _____ Dose # 3 _____	Dates Polio received: Dose #1 _____ Dose #2 _____ Dose #3 _____ Dose # 4 _____ Dose # 5 _____	Date(s) received: _____ _____ Age when last dose received: _____
Dates Diphtheria received: _____ _____ _____	Dates Mumps received: _____ _____	--OR-- 2 doses of Varicella Vaccine if no history of disease: Varicella #1 _____ Varicella #2 _____	<i>Submission of antibody titires showing immunity is acceptable in lieu of vaccines. Please include copy of lab results showing immunity</i>		
Date(s) Pertussis received: _____ _____ _____	Dates Rubella received: _____ _____	<i>Submission of antibody titires showing immunity is acceptable in lieu of vaccines. Please include copy of lab results showing immunity.</i>			
<i>For office use only:</i> <div style="border: 1px solid black; width: 100px; height: 20px;"></div>	<i>Submission of antibody titires showing immunity is acceptable in lieu of vaccines. Please include copy of lab results showing immunity.</i>				

Optional Vaccines given at Hope College:	TB testing done at Hope College
Type: _____ Date: _____	Type: _____ Date: _____ Result: _____
Type: _____ Date: _____	Type: _____ Date: _____ Result: _____
Type: _____ Date: _____	Type: _____ Date: _____ Result: _____

Not required: Please complete if you have already received

<u>Hepatitis A</u>	<u>HPV</u>	<u>Typhoid</u>	<u>Yellow Fever</u>
Dose # 1 _____ Dose # 2 _____	Dose # 1 _____ Dose # 2 _____ Dose # 3 _____	Dose #1 _____ Dose # 2 _____	Dose #1 _____ Dose #2 _____
		<i>Indicate oral or IM</i>	

INTERNATIONAL STUDENT HEALTH HISTORY FORM (continued)

PERSONAL & FAMILY HEALTH HISTORY

Height: Weight: Medication Allergies (list): Medications taken regularly: Hospitalizations/Surgeries: 	<p style="text-align: center;">Mark all that apply:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 20%; text-align: center;">Myself</th> <th style="width: 20%; text-align: center;">Family</th> </tr> </thead> <tbody> <tr> <td colspan="3">AutoImmune Disorders:</td> </tr> <tr> <td>Diabetes</td> <td></td> <td></td> </tr> <tr> <td>Multiple Sclerosis</td> <td></td> <td></td> </tr> <tr> <td>Systemic Lupus</td> <td></td> <td></td> </tr> <tr> <td>Other:</td> <td></td> <td></td> </tr> <tr> <td colspan="3">Blood Disorders:</td> </tr> <tr> <td>Anemia</td> <td></td> <td></td> </tr> <tr> <td>Clotting</td> <td></td> <td></td> </tr> <tr> <td>Deficiency</td> <td></td> <td></td> </tr> <tr> <td>Other:</td> <td></td> <td></td> </tr> <tr> <td colspan="3">Cancer</td> </tr> <tr> <td>Specify:</td> <td></td> <td></td> </tr> <tr> <td colspan="3">Cardio/Pulmonary Disorders:</td> </tr> <tr> <td>Asthma</td> <td></td> <td></td> </tr> <tr> <td>Blood Clots</td> <td></td> <td></td> </tr> <tr> <td>Heart Murmur</td> <td></td> <td></td> </tr> <tr> <td>Heart Disease</td> <td></td> <td></td> </tr> <tr> <td>High Blood Pressure</td> <td></td> <td></td> </tr> <tr> <td>High Cholesterol</td> <td></td> <td></td> </tr> <tr> <td>Other:</td> <td></td> <td></td> </tr> </tbody> </table>		Myself	Family	AutoImmune Disorders:			Diabetes			Multiple Sclerosis			Systemic Lupus			Other:			Blood Disorders:			Anemia			Clotting			Deficiency			Other:			Cancer			Specify:			Cardio/Pulmonary Disorders:			Asthma			Blood Clots			Heart Murmur			Heart Disease			High Blood Pressure			High Cholesterol			Other:			<p style="text-align: center;">Mark all that apply:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 20%; text-align: center;">Myself</th> <th style="width: 20%; text-align: center;">Family</th> </tr> </thead> <tbody> <tr> <td colspan="3">Digestive Disorders:</td> </tr> <tr> <td>Crohn's Disease</td> <td></td> <td></td> </tr> <tr> <td>GERD</td> <td></td> <td></td> </tr> <tr> <td>Irritable Bowel</td> <td></td> <td></td> </tr> <tr> <td>Peptic Ulcer</td> <td></td> <td></td> </tr> <tr> <td>Other:</td> <td></td> <td></td> </tr> <tr> <td colspan="3">Eating Disorder:</td> </tr> <tr> <td>Anorexia Nervosa</td> <td></td> <td></td> </tr> <tr> <td>Binge Eating</td> <td></td> <td></td> </tr> <tr> <td>Bulimia</td> <td></td> <td></td> </tr> <tr> <td>Other:</td> <td></td> <td></td> </tr> <tr> <td colspan="3">Mental/Emotional Disorders:</td> </tr> <tr> <td>Anxiety</td> <td></td> <td></td> </tr> <tr> <td>Depression</td> <td></td> <td></td> </tr> <tr> <td>Suicide Attempt</td> <td></td> <td></td> </tr> <tr> <td>Other:</td> <td></td> <td></td> </tr> <tr> <td colspan="3">Neurological Disorders:</td> </tr> <tr> <td>ADD/ADHD</td> <td></td> <td></td> </tr> <tr> <td>Cerebral Palsy</td> <td></td> <td></td> </tr> <tr> <td>Migraine Headaches</td> <td></td> <td></td> </tr> <tr> <td>Seizures</td> <td></td> <td></td> </tr> <tr> <td>Other:</td> <td></td> <td></td> </tr> </tbody> </table>		Myself	Family	Digestive Disorders:			Crohn's Disease			GERD			Irritable Bowel			Peptic Ulcer			Other:			Eating Disorder:			Anorexia Nervosa			Binge Eating			Bulimia			Other:			Mental/Emotional Disorders:			Anxiety			Depression			Suicide Attempt			Other:			Neurological Disorders:			ADD/ADHD			Cerebral Palsy			Migraine Headaches			Seizures			Other:		
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Other Immunization History - Indicate ONLY if already provided

BCG Vaccine	Hepatitis A	Typhoid	Yellow Fever	Other (Specify):
Date: _____	Date: _____ Date: _____ Date: _____	Date: _____ Date: _____ Date: _____	Date: _____ Date: _____ Date: _____	Name _____ Date _____ _____ _____

STATEMENT OF AUTHORIZATION

- The information contained on this form is complete and I have not withheld any medical or mental health information. If any aspect of my health profile changes after submitting this form, I will notify the Hope Health Center of this/these change(s) in writing.
- I authorize the Student Health Center of Hope College to administer medical and surgical services, including immunizations and to perform routine and emergency diagnostic and therapeutic procedures as deemed necessary by duly licensed medical personnel. I understand that the Medical Director, or designee, serves as primary physician for medical care provided by the Hope Student Health Center.
- I understand that I will be required to undergo medical treatment for any current or future diagnosis of Latent Tuberculosis Infection (LTBI). *Failure to do so will result in withdrawal from current coursework and living arrangements at Hope College.*

Signature of Student

Date