

INTERNATIONAL STUDENT Health History Form



NORTHWEST MISSOURI STATE UNIVERSITY Wellness Services

800 University Drive ■ Maryville, MO 64468 ■ 660.562.1348 ■ fax: 660.562.1585 ■ email: health@nwmissouri.edu

Welcome to Northwest!

The Wellness Center is your first step to success at Northwest. Please bring printed copies of the documentation listed below (including this form) with you to your initial visit. If you have a scheduled appointment, please be on-time and have all forms with you in order to expedite your visit.

We Look forward to Meeting you!

Compliance Checklist

- › Physician Verification – **Must be completed by a physician** – Page 2
 - Proof of Two (2) MMR Vaccinations
 - Proof of One (1) Meningococcal Conjugate Vaccine after the age of 16 (If living on campus)
- Each vaccine is expensive, therefore, we highly encourage you to receive these vaccines prior to coming to Northwest.
- › Northwest Missouri State University's Health History Form – Pages 3 & 4
- › Written documentation of ANY treatment for active TB infection

Insurance Information

Below you will find some helpful contact information for LewerMark:

- LewerMark Customer Services Toll Free: 800-821-7710 (Monday – Friday 8:00 a.m. – 6:00 p.m.)
- Website: www.lewermark.com
- Email: lewermarksupport@lewer.com
- Northwest School Webpage: www.lewermark.com/nwmissouri
- My nurse 24/7: 866-549-5076 (provides you with free access to speak to a nurse regarding your health questions)

THIS FORM, AND IMMUNIZATION RECORDS, MUST BE COMPLETED AND SUBMITTED BY THE FOLLOWING DATES:

Fall Trimester – Aug. 1

Spring Trimester – Dec. 1

Summer Trimester – April 1

Please return directly to Wellness Services, DO NOT submit with other Admissions materials.

Failure to submit this required information by these dates can result in a hold being placed on your account - please return all forms completed by the specified dates.

**If you have a disability or significant health problem, please contact
Wellness Services before coming to campus.**

Vaccination Requirements

In addition to the required vaccination information requested below, please send us copies of any other vaccination records that you may have.

Measles, Mumps and Rubella (MMR) Vaccination

Required for all students

Northwest Missouri State University policy requires that ALL newly enrolled students have two MMRs at least 28 days apart.

Meningococcal vaccination requirement

Required for all students living on campus

Effective July 1, 2016, Missouri state law requires all students residing in residence halls have received the conjugate vaccine (or a booster dose) after the age of 16 **and** within five years of initial enrollment.

Physician Verification

(Must Be Completed and Submitted Prior to Arrival to Northwest)

Name of Student _____ Date of Birth: _____

Measles Mumps Rubella (MMR)

(You must have had 2 of these vaccines at least 28 days apart)

DATE OF DOSE 1 : _____

DATE OF DOSE 2 : _____

Please list any other vaccines you have had:

Meningococcal Conjugate Vaccine (Meningitis - ACWY)

(Required if living on campus)

DATE OF DOSE : _____

If you have had prior treatment for active TB disease or latent TB infection medication treatment, written documentation must be submitted prior to arrival.

Student Signature

Date

Signature of parent (if student is under 18 years of age)

Date

Signature of Health Care Provider

Date

Official seal of hospital or clinic (must have official seal to make this a valid document)

Health History Form

International Students



OFFICE USE ONLY

MMR 1 ____/____/____
MMR 2 ____/____/____
MN ____/____/____ or OC
IGRA EXEMPT or NEEDED

Health History Form - International Students

Personal information

Last name (Maiden name) Legal First Name Middle Preferred Name

Address City State ZIP

Phone Student's Cell phone Cell Phone Carrier (For Text Reminders)

Date of birth Country of birth

Preferred Spoken Language(s)

I identify my gender as...

- Male Female
- Transgender man / Transman
- Transgender woman / Transwoman
- Genderqueer / Gender nonconforming
- Additional identity (fill in) _____

Medical history

Do **YOU** have a present or past history of the following: (check all that apply)

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Intestinal/stomach trouble/colitis | <input type="checkbox"/> Rubella (3-day measles) |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Ear trouble/hearing loss | <input type="checkbox"/> Joint disease/injury | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Measles, Red | <input type="checkbox"/> Sexually trans. infection (STI) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eye disease/problems | <input type="checkbox"/> Menstrual problems | <input type="checkbox"/> Sickle Cell Trait/Anemia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gallbladder trouble | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Hay fever (recurrent) | <input type="checkbox"/> Mononucleosis, infectious | <input type="checkbox"/> Skin problems (chronic) |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Head injury | <input type="checkbox"/> Mumps | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Headache (recurrent) | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Smoking (how long?) _____ |
| <input type="checkbox"/> Cough (chronic) | <input type="checkbox"/> Heart disease/problems | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Spleen, surgical removal |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> Polio | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hernia/rupture | <input type="checkbox"/> Psychological counseling | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Disability/Handicap | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Urinary tract infection |
| <input type="checkbox"/> Other _____ | | | <input type="checkbox"/> NONE OF THE ABOVE |

Current medications (list all, including birth control)

Do you have allergies to drugs, foods, metals? Yes / No

Hospitalizations/surgeries

What are they? _____

N/A

N/A

N/A

Family history (place relationship in blank)

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Alcohol/drug abuse _____ | <input type="checkbox"/> Death before 50 _____ | <input type="checkbox"/> Elevated cholesterol _____ | <input type="checkbox"/> Hypertension/stroke _____ |
| <input type="checkbox"/> Cancer/type _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Heart disease _____ | <input type="checkbox"/> Mental illness _____ |

HIPAA Notice of Privacy Practices Acknowledgment

By signing below I acknowledge receipt of Wellness Service' Notice of Privacy Practices, which is available to me at: <https://www.nwmissouri.edu/wellness/PDF/NoticeOfPrivacyPractices.pdf>

By signing below I acknowledge that this serves as a consent to receive treatment from Wellness Services, as outlined here: <https://www.nwmissouri.edu/wellness/PDF/TreatmentAgreement.pdf>

Student Signature _____ Date: _____

Students Under 18

I grant permission to University Wellness Services (to include clinic, counseling, and health education services.) Northwest Missouri State University, to treat my son/daughter as may be necessary, and to refer to private care when special service is needed.

Parent/Guardian Signature _____ Date: _____

Name: _____

Date of Birth: _____

919 Number: _____

Phone Number: _____

Tuberculosis (TB) Screening questionnaire

Have you ever had a positive TB skin test? YES NO

Have you ever had close contact with anyone who was sick with TB? YES NO

Were you born in one of the countries listed below and arrived in the U.S. within the past 5 years?
(If yes, please CIRCLE the country) YES NO

Have you ever traveled to/in one or more of the countries listed below?
(If yes, please CHECK the country/ies AND indicate the date(s) and duration of travel) YES NO

- | | | | | | | |
|---|--|--|---|---|--|---|
| <input type="checkbox"/> Afghanistan | <input type="checkbox"/> Cabo Verde | <input type="checkbox"/> El Salvador | <input type="checkbox"/> Kenya | <input type="checkbox"/> Morocco | <input type="checkbox"/> Romania | <input type="checkbox"/> Uganda |
| <input type="checkbox"/> Algeria | <input type="checkbox"/> Cambodia | <input type="checkbox"/> Equatorial Guinea | <input type="checkbox"/> Kiribati | <input type="checkbox"/> Mozambique | <input type="checkbox"/> Russian Federation | <input type="checkbox"/> Ukraine |
| <input type="checkbox"/> Angola | <input type="checkbox"/> Cameroon | <input type="checkbox"/> Eritrea | <input type="checkbox"/> Kuwait | <input type="checkbox"/> Myanmar | <input type="checkbox"/> Rwanda | <input type="checkbox"/> United Republic of Tanzania |
| <input type="checkbox"/> Anguilla | <input type="checkbox"/> Central African Republic | <input type="checkbox"/> Eswatini | <input type="checkbox"/> Kyrgyzstan | <input type="checkbox"/> Namibia | <input type="checkbox"/> Sao Tome and Principe | <input type="checkbox"/> Uruguay |
| <input type="checkbox"/> Argentina | <input type="checkbox"/> Chad | <input type="checkbox"/> Ethiopia | <input type="checkbox"/> Lao People's Democratic Republic | <input type="checkbox"/> Nauru | <input type="checkbox"/> Senegal | <input type="checkbox"/> Uzbekistan |
| <input type="checkbox"/> Armenia | <input type="checkbox"/> China | <input type="checkbox"/> Fiji | <input type="checkbox"/> Latvia | <input type="checkbox"/> Nicaragua | <input type="checkbox"/> Sierra Leone | <input type="checkbox"/> Vanuatu |
| <input type="checkbox"/> Azerbaijan | <input type="checkbox"/> China, Hong Kong SAR | <input type="checkbox"/> French Polynesia | <input type="checkbox"/> Lesotho | <input type="checkbox"/> Niger | <input type="checkbox"/> Singapore | <input type="checkbox"/> Venezuela (Bolivarian Republic of) |
| <input type="checkbox"/> Bangladesh | <input type="checkbox"/> China, Macao SAR | <input type="checkbox"/> Gabon | <input type="checkbox"/> Liberia | <input type="checkbox"/> Nigeria | <input type="checkbox"/> Solomon Islands | <input type="checkbox"/> Viet Nam |
| <input type="checkbox"/> Belarus | <input type="checkbox"/> Colombia | <input type="checkbox"/> Gambia | <input type="checkbox"/> Libya | <input type="checkbox"/> Niue | <input type="checkbox"/> Somalia | <input type="checkbox"/> Yemen |
| <input type="checkbox"/> Belize | <input type="checkbox"/> Comoros | <input type="checkbox"/> Georgia | <input type="checkbox"/> Lithuania | <input type="checkbox"/> Northern Mariana Islands | <input type="checkbox"/> South Africa | <input type="checkbox"/> Zambia |
| <input type="checkbox"/> Benin | <input type="checkbox"/> Congo | <input type="checkbox"/> Greenland | <input type="checkbox"/> Madagascar | <input type="checkbox"/> Pakistan | <input type="checkbox"/> South Sudan | <input type="checkbox"/> Zimbabwe |
| <input type="checkbox"/> Bhutan | <input type="checkbox"/> Democratic People's Republic of Korea | <input type="checkbox"/> Guam | <input type="checkbox"/> Malawi | <input type="checkbox"/> Palau | <input type="checkbox"/> Sri Lanka | |
| <input type="checkbox"/> Bolivia (Plurinational State of) | <input type="checkbox"/> Democratic Republic of the Congo | <input type="checkbox"/> Guatemala | <input type="checkbox"/> Malaysia | <input type="checkbox"/> Panama | <input type="checkbox"/> Sudan | |
| <input type="checkbox"/> Bosnia and Herzegovina | <input type="checkbox"/> Djibouti | <input type="checkbox"/> Guinea | <input type="checkbox"/> Maldives | <input type="checkbox"/> Papua New Guinea | <input type="checkbox"/> Suriname | |
| <input type="checkbox"/> Botswana | <input type="checkbox"/> Dominican Republic | <input type="checkbox"/> Guinea-Bissau | <input type="checkbox"/> Mali | <input type="checkbox"/> Paraguay | <input type="checkbox"/> Tajikistan | |
| <input type="checkbox"/> Brazil | <input type="checkbox"/> Dominica | <input type="checkbox"/> Guyana | <input type="checkbox"/> Malta | <input type="checkbox"/> Peru | <input type="checkbox"/> Thailand | Date: _____ |
| <input type="checkbox"/> Brunei Darussalam | <input type="checkbox"/> Dominican Republic | <input type="checkbox"/> Haiti | <input type="checkbox"/> Marshall Islands | <input type="checkbox"/> Philippines | <input type="checkbox"/> Timor-Leste | Duration: _____ |
| <input type="checkbox"/> Bulgaria | <input type="checkbox"/> Ecuador | <input type="checkbox"/> Honduras | <input type="checkbox"/> Mauritania | <input type="checkbox"/> Qatar | <input type="checkbox"/> Togo | Date: _____ |
| <input type="checkbox"/> Burkina Faso | | <input type="checkbox"/> India | <input type="checkbox"/> Mexico | <input type="checkbox"/> Republic of Korea | <input type="checkbox"/> Tokelau | Duration: _____ |
| <input type="checkbox"/> Burundi | | <input type="checkbox"/> Indonesia | <input type="checkbox"/> Micronesia (Federated States of) | <input type="checkbox"/> Republic of Moldova | <input type="checkbox"/> Tunisia | Date: _____ |
| <input type="checkbox"/> Côte d'Ivoire | | <input type="checkbox"/> Iraq | <input type="checkbox"/> Mongolia | | <input type="checkbox"/> Turkmenistan | Duration: _____ |
| | | <input type="checkbox"/> Kazakhstan | | | <input type="checkbox"/> Tuvalu | |

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2020. Countries with incidence rates of ≥20 cases per 100,000 population. For further updates, refer to <http://www.who.int/tb/country/en/>

Have you ever been a resident and/or employee of any high risk congregate settings (e.g. correctional facilities, long-term care facilities, and homeless shelters)? YES NO

Have you ever been a volunteer or health-care worker who served clients who were at increased risk for active TB disease? YES NO

Have you ever been a member of any of the following groups that may have an increased incidence of latent *M. tuberculosis* infection or active TB disease – medically underserved, low-income, or abusing drugs or alcohol? YES NO

If you answered **YES** to any of the above, you must:

- **Schedule a TB test** with Wellness Services
- **OR**
- Provide documentation of a **TB test done in the United States** within the past 12 months. TB tests done outside of the United States will not be accepted.
- **If prior treatment for active TB disease or latent TB infection has been completed, written documentation must be submitted.**

Chest X-rays will be required for anyone with a positive test.

Additional American College Health Association immunization recommendations:

- Polio
- Tetanus, Diphtheria, Pertussis
- Hepatitis A
- Influenza
- Varicella
- Human Papillomavirus
- Hepatitis B
- Pneumococcal
- COVID-19