WAKE TECH COMMUNITY COLLEGE

INTERNATIONAL (F-1) STUDENT MEDICAL FORM

Important: The following sections must be completed before submitting this form to the International Student Office. Health forms lacking completion of these sections will not be considered valid. **Failure to submit a valid health form by the indicated deadline will result in your admission application being incomplete.** Students should make and retain a copy of their health forms for their personal records prior to submitting it to the College. A physician, physician assistant, or nurse practitioner must complete your physical exam.

REPORT OF MEDICAL HISTORY

To be completed and signed by student ***(Please print in black Ink)***

Last Name (print) _____ First Name _____ Middle Name _____

Permanent Address _____ City _____ State _____ Zip Code _____ Area Code/Phone Number _____

Date of Birth (mo/day/yr) _____ Gender ☐ M ☐ F Marital Status ☐ S ☐ M ☐ Other

Previously enrolled here ☐ Yes ☐ No

If yes, dates _____

Semester Entering: ☐ Fall ☐ Spring ☐ Summer Year 20 ____

Hospital/Health Insurance (Name and Address of Company) _____ Area Code/Phone Number _____

Name of Policy Holder _____ Employer _____

Is this an HMO/PPO/Managed Care Plan? ☐ Yes ☐ No

Policy or Certificate Number _____ Group Number _____

Name of person to contact in case of an emergency _____ Relationship _____

Address _____ City _____ State _____ Zip Code _____ Area Code/Phone Number _____

The following health history is confidential, except in an emergency situation or by court order, will not be released without your written permission. Your health history does not affect your admission status. Please attach additional sheets for any items that require fuller explanation.

Personal Health History

Please answer all questions, indicate comments on all positive answers on a separate paper.

HAVE YOU HAD	YES	NO		YES	NO		YES	NO		YES	NO
Eye Trouble	☐	☐	Frequent or Severe Respiratory Infections	☐	☐	Kidney or Bladder Disease	☐	☐	Diseases ↓	☐	☐
Ear, Nose, Throat Trouble	☐	☐	Rheumatic Fever or Heart Mummer	☐	☐	Disease or injury of Bones or Joints	☐	☐	Infectious	☐	☐
Frequent or Severe Headaches	☐	☐	Stomach or Intestinal Trouble	☐	☐	"Tick" Knee, Shoulder, etc.	☐	☐	Female Only: ↓	☐	☐
Epilepsy	☐	☐	Hepatitis or Jaundice	☐	☐	Anemia	☐	☐	Irregular Periods	☐	☐
Asthma, High Fever	☐	☐							Severe Cramps	☐	☐
Tuberculosis	☐	☐							Extensive Flow	☐	☐

	YES	NO	Explanation
Do you have any conditions or disabilities that limit your physical activities? (If yes, please describe)	☐	☐	
Have you ever been a patient in any type of hospital? (Specify when, where, and why.)	☐	☐	
Has your academic career been interrupted due to physical or emotional problems? (Please explain)	☐	☐	
Is there loss or seriously impaired function of any paired organs? (Please describe.)	☐	☐	
Other than for a routine check-up, have you seen a physician or health-care professional in the past six months? (Please describe.)	☐	☐	
Have you ever had any serious illness or injuries other than those already noted? (Specify when and where and give details.)	☐	☐	

Please read and sign the statement below (or parent/guardian, if student is under the age of 18):

I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless otherwise permitted by law. If I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the institution to release information from my (son/daughter's) medical record to a physician, hospital, or other medical professional involved in providing me (him/her) with emergency treatment and/or medical care.

Signature of Student _____ Date _____

Signature of Parent/Guardian, if student is under the age 18 _____ Date _____

Physical Examination (required)

To be completed and signed by a licensed physician or clinic *(Please print in black ink.)*

Last Name _____ First Name _____ Middle Name _____ Date of Birth _____

Permanent Address _____ City _____ State _____ Zip Code _____ Area Code/Phone Number _____

Height _____ Weight _____ BP _____/_____ Pulse _____ /min.

Vision: Corrected Right 20/ _____ Left 20/ _____/_____ Hearing (gross) Right _____

Uncorrected Right 20/ _____ Left 20/ _____/_____ Left _____

Hematocrit _____ %

Urinalysis

Sugar _____

Albumin _____

Micro _____

Are there abnormalities?	Normal	Abnormal
Head, Ears, Nose, Throat	☐	☐
Eyes	☐	☐
Respiratory	☐	☐
Cardiovascular	☐	☐
Gastrointestinal	☐	☐
Hernia	☐	☐
Genitourinary	☐	☐
Musculoskeletal	☐	☐
Metabolic/Endocrine	☐	☐
Neuropsychiatric	☐	☐
Skin	☐	☐
Mammary	☐	☐

IMMUNIZATIONS	mo./day/yr (#1)	mo./day/yr (#2)	mo./day/yr (#3)	mo./day/yr (#4)
DTP or Td(within the last 10 yrs)				
Td Booster				
Polio				
MMR (after first birthday)				
MR (after first birthday)				
Measles (after first birthday)				
Mumps				
Rubella				
BCG Vaccine				

Please note: A TB test is required and must be administered within the last 12 months. If the TB test is positive, a chest x-ray result is required within the last 12 months.

QuantiFERON TB Gold	PPD Skin Test
Date of TB Gold test: _____ (mm/dd/yy)	Date of TB PPD test: _____ (mm/dd/yy)
	mm induration: _____
Please check: ☐ negative ☐ positive	Please check: ☐ negative ☐ positive
If TB is positive, chest x-ray result:	Date
	Results
Treatment (if applicable): Date	

A. Is there loss or seriously impaired functions of any paired organs? Yes ☐ No ☐

If yes, please explain: _____

B. Is student under treatment for any medical or emotional condition? Yes ☐ No ☐

If yes, please explain: _____

C. Recommendation for physical activity (physical education, intramurals, etc.) Unlimited _____ Limited _____

If limited, please explain: _____

D. Is student physically and emotionally healthy? Yes ☐ No ☐

If no, please explain: _____

Signature or Clinic Stamp REQUIRED:

Signature of Physician/Physician Assistant/Nurse Practitioner _____ **Date** _____

Print Name of Physician/Physician Assistant/Nurse Practitioner _____ **Area Code/Phone Number** _____

Office Address _____ **City** _____ **State** _____ **Zip Code** _____