WESTERN
TEXAS COLLEGE

International Student Health Record Form

Please type or print clearly in ink

Enrollment Year: ______ Semester: Fall Spring

Student's Last Name	First Name	Middle Name	Marital Status (S, M, D)
Date of Birth (MM-DD-YY)	Gender	Country of Citizenship	Social Security Number
Permanent Home Address			Student Cell Phone
City	State	Country	Zip
Emergency Contact Name	Relationship	City/State	Phone
Name of Medical Insurance		Policy Number	Phone

PLEASE MAKE A COPY OF BOTH SIDES OF YOUR HEALTH INSURANCE CARD, IF AVAILABLE, AND SUBMIT COPY WITH THIS FORM.

Required Immunizations

Please provide documentation of the following:

Meningococcal Disease (Meningitis) – Menactra (MCV4) or Menomune (MPSV4)
- Required by Texas law for all students under 30 years of age.
- Certain exceptions apply
- Vaccine must be received at least 10 days (but not more than 5 years) prior to first day of class.

Tetanus – Primary series typically received in childhood.
- Booster required within past 10 years (Td or Tdap).
- Tdap preferred since 2005 to help protect against pertussis ("whooping cough").

MMR (Measles, Mumps, Rubella) – 2 shot series, usually received in childhood.
- Required if born after 1956.

Recommended Immunizations
- Hepatitis A, Hepatitis B
- Varicella (if never had chickenpox)
- Influenza (flu)-annually

Acceptable records demonstrating your immunizations may be obtained from any of the following:
- Immunization Form verified by signature or stamp of a physician or other licensed health care professional.
- Official Immunization Record generated from a state or local health department.
- Immunization Record from high school or previous college/university (must have an official stamp or signature). These immunization records do not transfer automatically; you must request a copy.

Be certain that your name appears on-each page of any records you submit. Submitting all forms together is preferable. The records must include the dates of vaccine administration - including the month, day, and year. All records must be in English. Please keep a copy for your records.

Medical Information

This information is requested to be available in the event of emergency and will not be reviewed by admissions staff to determine eligibility for admission.

Have you ever had any of the following? Please provide futher explanations below as needed.

Allergic to:
Medication, specify: ______________
Latex
Foods, specify: __________________
Insect
Other:_________________________
Anaphylactic shock,
Epipen (epinephrine) use
Asthma

Cancer
Diabetes
Depression / anxiety
Other mental health issues
Epilepsy / seizures / convulsions
Fainting
Head injury / concussion
Heart disease or irregularity
High blood pressure

Handicap (visual, auditory, neurological, mental, musculoskeletal, etc.)
Immune system disorder
Tumor or cyst
Severe menstrual problems
Severe migraines
Surgery (appendix, gall bladder, tonsils, etc.)
Other:__________________

If you have any further medical or surgical history that you find important for the medical staff to have on record, please provide details here (or attach further documentation if needed).

Current prescription medications:

Tuberculosis (TB) Screening Questions

Please answer the following questions:

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
Have you ever been vaccinated with BCG (tuberculosis vaccine given commonly outside the USA)? Yes No
Were you born in, or within the past 5 years, have you lived in or traveled for more than a month in, any country other than those listed below? Yes No

American Samoa, Australia, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Jamaica, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, New Zeland, Norway, Saint Kitts and Nevis, Saint Lucia, San Marino, Sweden, Switzerland, United Kingdom, or USA.

If the answer to all of the above questions is NO, then no further action is required.
If the answer to ANY of the above questions is YES, then you will need further assessment performed by your health care provider or your local city health department. Please complete the Tuberculosis (TB) Risk Assessment Form and return the completed form.

To the best of my knowledge, I certify that the information provided on this form and all attached immunization records are accurate and complete.

I hereby grant Western Texas College permission to seek medical and surgical services, immunizations, therapeutic procedures, and emergency medical services without liability, if the need arises. In the event of an emergency, I also authorize the Western Texas College to release (by fax, photocopy, or verbal communication) the information contained within this Health Record Form to the treating hospital, physician, and/or medical staff.

Student Signature	Date	Parent Signature *If student is under 18*	Date

Please scan the completed, signed form and your insurance card. Submit via email to: mdoucette@wtc.edu.

This form can also be mailed to: Western Texas College
International Student Office
6200 College Avenue
Snyder, Texas 79549