

Complete This Form BEFORE Entering the USA!

Student Health History

Name _____
(Last) (First) (Middle)

Date of Birth _____ Male _____ Female _____
(Month) (Day) (Year)

Address _____
(Street) (City) (State / Country)

In case of emergency, please contact: (Name, Relationship, Phone, Email)

Vaccine	Type	Dose	Date MM/DD/YY	Vaccine	Type	Dose	Date MM/DD/YY
Diphtheria/ Tetanus Pertussis (DTP or DT)		1		Measles Mumps Rubella (MR or MMR)		1	
		2				2	
		3		Had Measles Blood Titres			
		4		Had Mumps Blood Titres			
		5		TB Mantoux Test	_____ mm of Induration		
Tetanus/ Diphtheria (Adult)	Td	1		Chest x-ray Report			
	Td	2		Other Vaccines			
	Td	3					
	Td	4					
Polio (Specify OPV or IPV)		1					
		2					
		3					
		4					
		5					

Allergies

Medical: _____

Food: _____

Plant: _____ Insect: _____

Other: _____

List any medications used for allergies: _____