

## INTERNATIONAL STUDENT MEDICAL HISTORY

The first three pages must be completed, signed, and returned to GIAL's International Student Center. They become part of your Application paper work. Return them by fax, air mail or as a scanned pdf attached to an email. If scanned, bring the original copy with you when you come to the US. Please read page 4. It will need to be filled out by a doctor, signed by you, and returned to the ISC within a week after beginning classes.

### Personal Information

First Semester of Enrollment: Fall Spring Summer Year \_\_\_\_\_

Family/Surname \_\_\_\_\_ First/given \_\_\_\_\_ Middle \_\_\_\_\_ Male Female

\_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address Month/Day / Year

\_\_\_\_\_ City \_\_\_\_\_ Province/State \_\_\_\_\_ Postal Code \_\_\_\_\_ Country

Home Phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Other: \_\_\_\_\_

Social Security number : \_\_\_\_\_

Marital Status: Single Married Divorced Widowed Citizenship: \_\_\_\_\_

Next of Kin: Spouse Parent(s) Guardian Other Name: \_\_\_\_\_

Address if different than above: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Other: \_\_\_\_\_

Health Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

### Medical Information

Please answer all questions. Comment on all positive answers in this section using the next sheet with certifying signature.

<b>Have you ever had</b>	10	19
<b>Yes.....No</b>		
01 Scarlet Fever.....	Insomnia.....	Asthma.....
02	11	20 Shortness of breath.....
Measles.....	Hepatitis.....	21 Hay Fever.....
03 German Measles (Rubella).....	12 Frequent anxiety.....	22
04	13 Frequent depression.....	Allergy.....
Mumps.....	14 Worry or nervousness.....	a. Penicillin.....
05 Chicken Pox	15 Mental Illness.....	b. Sulfonamides.....
06		c. Serum.....
Diabetes.....	<b>Yes.....No</b>	d. Foods.....
07	16 Recurrent colds.....	e. Others.....
Malaria.....	17 Head injury with unconsciousness.....	
08 HIV (Tested Positive).....	18 Epilepsy, convulsions.....	23 Dizziness, fainting.....
09		
Tuberculosis.....		





- Dose 2 Date \_\_\_\_/\_\_\_\_
- Dose 3 Date \_\_\_\_/\_\_\_\_

**F.Meningitis Immunization** (Highly recommended for college-aged students)

**Menomune** (dosage \_\_\_\_ ) or **Menactra** (dosage \_\_\_\_)

\_\_\_\_/\_\_\_\_

**G.Fluzone (Flu-annually)**

\_\_\_\_/\_\_\_\_

I certify all questions have been answered correctly and completely

\_\_\_\_\_  
Student's Signature

**Student Treatment Consent and Release**

In case of illness or accident, I give the Graduate Institute of Applied Linguistics (GIAL) and its representative(s) full permission to secure medical, dental, and/or surgical care that may include transportation to a doctor or hospital of their choice, injections, examination, medication, and surgery that is considered necessary for my good health. I agree to pay all medical costs and fees, including costs and fees for all emergency medical treatment and transportation. In all events, I understand and agree that GIAL does not have any liability or responsibility for any injury or damage that may arise from such medical, dental, and/or surgical care. In case of serious illness, I give GIAL and its representative(s) permission to contact next of kin listed on my medical history.

\_\_\_\_\_  
Student's Signature

**Notice: GIAL has the option to require a check-up by a physician if one is indicated by information on this form.**

Page 3 - 7/22/2010 maj - International Student Health Form

Please return this form to GIAL International Student Center / 7500 W. Camp Wisdom Road / Dallas, TX 75236 within one week of beginning classes.

### Tuberculosis

Because of the increase in occurrence of TB not only in Texas but world-wide, you will be required to be tested during your first week at GIAL.

If you come from an area of the world where TB is prevalent, you may want, in addition, to be tested 3-6 months before arrival at GIAL so that you can receive treatment for TB, if it is needed, before you arrive. Then you would not have to miss any classes once you get here.

The following must be filled out and signed by a physician:

Tuberculosis – check appropriate box.

- a.  PPD (Mantoux) test within the past 6 months (monovac not acceptable) Month/ Year  
\_\_\_\_/\_\_\_\_  
Result:      Positive      Negative  
If positive: Type of Test \_\_\_\_\_ Reading in mm: \_\_\_\_\_
- b.  Have had BCG as a child; Quaniferon Gold blood test is required \_\_\_\_/\_\_\_\_  
Result:      Positive      Negative
- c.  Positive PPD or Quaniferon Gold test – chest x-ray required. Give date and result of chest x-ray. \_\_\_\_/\_\_\_\_  
Result:      Positive      Negative  
If positive: Facility where x-ray was done: \_\_\_\_\_

Attending Physician – Please print information

Name \_\_\_\_\_ Title \_\_\_\_\_ Phone Number \_\_\_\_\_  
Signature \_\_\_\_\_ Address \_\_\_\_\_

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Student's Signature

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