Student Name: ___________________________ Student ID Number: _________________________

International Student Health Information Form

Complete and return to Student Health Services by:

MAIL	OR	Medical FAX
201 Plageman Building		541-737-9665
Corvallis, OR 97331-8567		PHONE
ATTN: Immunization Coordinator		541-737-7573

What is your preferred name? ____

Please circle your legal sex: female male

Please circle your gender: female male transgender other_________________________________

Please indicate preferred pronoun: she he other ____________________________

Circle any health issues you have now or have had in the past:

Visual impairment (not correctable)
Hearing impairment
Physical disability
Autism
ADHD/ADD
Learning disability (not ADHD)
Seasonal allergies
Eczema
Asthma
Pneumonia
Heart Attack
High Cholesterol
High Blood Pressure
Palpitations/Arrhythmia
Congenital Heart defect
Stroke
Clotting disorder/DVT or Thrombosis
Bleeding Disorder

Sickle Cell disease
Thalassemia
Migraine headaches
Seizures
Concussion
Traumatic Brain Injury
Diabetes Type 1
Diabetes Type 2
Thyroid problem
Polycystic Ovarian Syndrome
Chronic Kidney Disease
Kidney Infection
Celiac disease
Crohn's disease
Ulcerative Colitis
Liver disease
Rheumatoid Arthritis
Lupus
Fibromyalgia

Other chronic pain condition
Tuberculosis
Hepatitis B
Hepatitis C
HIV/AIDS
Chlamydia
Gonorrhea
Genital Herpes
Alcoholism or alcohol abuse
Substance addiction or abuse
Eating Disorder
Anxiety/Panic Attacks
Depression
Obsessive Compulsive Disorder (OCD)
Bipolar Disorder
History of suicide attempt
Post Traumatic Stress Disorder (PTSD)
Schizophrenia

Student Name: ____________________ Student ID Number: _________________

Have you ever been diagnosed with cancer? **Circle one: No Yes**

If yes, what type(s)?: ____

Do you have any other medical conditions or injuries not listed above? **Circle one: No Yes**

If yes, please list: ____

Have you ever had a surgery (for example wisdom teeth removed, tonsillectomy, appendectomy, hernia repair, fracture or joint repair)? **Circle one: No Yes**

If yes, please list: ____

Do you have any medication allergies? **Circle one: No Yes**

If yes, list name(s) of medication and type of reaction: ____

Have you ever had an anaphylactic or severe allergic reaction to anything other than a medication? **Circle one: No Yes**

If yes, list allergy(s) and type(s) of reaction: ____

Circle any health problems your biological parents, grandparents or siblings have had, if known. If you are adopted or you do not know your biological family medical history, please check here. ______

Blood clots	Diabetes	Mental health problems
Stroke	Kidney disease	Colon cancer
Heart Disease/Heart Attack	Thyroid disorder	Melanoma
High Blood Pressure	Drug or alcohol addiction	Breast cancer
High Cholesterol	Suicide or suicide attempt	Ovarian cancer

Are there any other hereditary health problems that run in your family that are not listed above? **Circle one: No Yes**

If yes, please list: ____

AUTHORIZATION FOR EMERGENCY CONTACT*:* Please contact the person named in the emergency contact section below if I am being hospitalized or treated for any emergency or life-threatening medical or psychological condition and am unable to contact them myself.

Emergency Contact:

Name: ____ Relationship: _____________________________________

Address: ____

Mobile phone: ____________________________________Other phone: _______________________________________

Student Name: ____________________ **Oregon State University OSU Student Health Services** studenthealth.oregonstate.edu Student ID Number: _________________

Immunization Information

Please list all dates in the month/day/year format (mm/dd/yyyy)

Required Vaccines:

A copy of official immunization documents or clinic stamp/provider signature MUST be included

MMR (Measles, Mumps, and Rubella combined): **Two (2) doses of MMR REQUIRED** **OR** **Two (2) doses of Measles, two (2) doses of Mumps, and one (1) dose of Rubella REQUIRED** **Lab tests (titers) may be substituted as proof of immunity in place of vaccinations.**	**Dose 1**_____/_____/_____ **Dose 2**_____/_____/_____ OR **Measles** **Dose 1**_____/_____/_____ **Dose 2**_____/_____/_____ **Mumps** **Dose 1**_____/_____/_____ **Dose 2**_____/_____/_____ **Rubella** **Dose 1**_____/_____/_____
Hepatitis B ☐ **OR Hepatitis A&B (TwinRix®)** ☐ **(Please check) Three (3) doses REQUIRED** **Lab tests (titers) may be substituted as proof of immunity in place of vaccinations.** **OR** **Indicate date of disease** (Must provide documentation for proof of date of disease).	**Dose 1**_____/_____/_____ **Dose 2**_____/_____/_____ **Dose 3**_____/_____/_____ OR **Date of disease** _____/_____/_____
Tdap (Tetanus, Diphtheria, Pertussis)-One (1) dose since 2005 REQUIRED	**Dose 1**_____/_____/_____
Varicella (Chicken Pox): **Two (2) doses REQUIRED** **Lab tests (titers) may be substituted as proof of immunity in place of vaccinations.** **OR** **Indicate date of disease** (Must provide documentation for proof of date of disease).	**Dose 1**_____/_____/_____ **Dose 2**_____/_____/_____ OR **Date of disease** _____/_____/_____
Meningococcal (MCV4, MenACWY) -REQUIRED of all students under the age of 22. Must have received one (1) dose since turning age 16 (Menactra®, Menveo®, Menomune®).	**Dose 1**_____/_____/_____

Recommended Vaccines:

Meningococcal B (*Not the same as the MCV4, MenACWY*) Highly recommended for full coverage against meningococcal disease.	**Bexsero®** **Dose 1**_____/_____/_____ **Dose 2**_____/_____/_____ OR **Trumenba®** **Dose 1**_____/_____/_____ **Dose 2**_____/_____/_____ **Dose 3**_____/_____/_____
Human Papillomavirus (HPV) Gardasil® or Gardasil®-9	**Dose 1**_____/_____/_____ **Dose 2**_____/_____/_____ **Dose 3**_____/_____/_____
Hepatitis A (Disregard if Hepatitis A&B, (TwinRix®), listed above).	**Dose 1**_____/_____/_____ **Dose 2**_____/_____/_____

Exemptions:

☐ I was born before January 1, 1957 (you are exempt from MMR and Varicella requirement).

☐ All students requesting a medical or non-medical waiver must come to Student Health Services in person to meet with a nurse or clinician before signing the waiver **(must be done within the first three weeks of your first term).**

☐ I have attached a copy of my immunization documentation ☐ I have attached a copy of my titer results

Health Care Provider Signature: **Signature/Stamp of authorized health care official required here only if photocopies not provided.**

Student Name: ____________________ Oregon State UNIVERSITY OSU Student Health Services studenthealth.oregonstate.edu Student ID Number: _________________

Tuberculosis (TB) Screening Questionnaire

OSU **requires** international students from high TB risk countries or who have lived in a high TB risk country for more than 6 months to complete TB screening upon arrival at OSU. The screening **must** be completed within the United States.

Please answer the following questions:

Are you from one of the high TB risk countries listed below? **(If yes, please CIRCLE the country below).** ☐Yes ☐No

Have you ever lived in one or more of the high TB risk countries listed below for more than 6 months? ☐Yes ☐No
(If yes, please CIRCLE the country below).

If you answered **YES** to any questions above, a TB screening is **required**.

If you answered **NO** to all of the above questions, no TB screening is required.

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

Source: World Health Organization (WHO) estimates of tuberculosis incidence by country, 2014. Countries with rates of ≥20 cases per 100.000 population.

Student Name: ___________________ **Oregon State UNIVERSITY OSU Student Health Services** studenthealth.oregonstate.edu Student ID Number: ________________

Notification of OSU Student Health Services Policies

PRIVACY AND CONFIDENTIALITY: With a student's consent, Student Health Services may disclose information for the purposes of providing medical treatment and bill the student's insurance company for services and treatment received.
In some circumstances Student Health Services providers may need to disclose health information without a student's written consent:

- If necessary to protect the health and safety of the student or others;
- As a result of a court order or subpoena;
- To verify to the university whether the student has completed all mandatory immunizations;
- Other instances required by law; for example, certain communicable diseases must be reported to the Benton County Health Department.

For more detail regarding confidentiality notification please consult: http://studenthealth.oregonstate.edu/general/policies-and-guidelines/privacy-and-confidentiality.

IMMUNIZATION REQUIREMENTS: OSU policies, Oregon State law (ORS 433.282 and 433.284) and the corresponding Administrative Rules (333-050-0130) require a completed series of Measles, Mumps, and Rubella (MMR) vaccinations. Along with the MMR vaccination, OSU polices also require Quadrivalent Meningococcal (MCV4), Hepatitis B, Tdap, and Varicella. For complete immunization information please refer to http://studenthealth.oregonstate.edu/general/policies-and-guidelines/immunizations-tb-screening-and-health-history. Immunization records and a completed health history form must be submitted to OSU Student Health Services within the first six weeks of your first term. **If this form and dates of immunization are not submitted within 6 weeks of your first date of attendance at OSU, a registration hold will be placed on your university account.**

RIGHTS AND RESPONSIBILITIES: Patients have the right to impartial access to treatment or accommodations that are available or medically necessary. Patients have the responsibility to provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to their health.
For more detail regarding rights and responsibilities, please consult: http://studenthealth.oregonstate.edu/general/policies-and-guidelines/rights-and-responsibilities.

CHARGES: There are charges for a number of services at Student Health Services, such as lab tests, x-rays, and immunizations. A list of common charges can be found on the SHS website: http://studenthealth.oregonstate.edu/general/fees-services/most-common-fees.

BILLING PRACTICES: Students presenting to SHS should bring their current insurance card and picture ID.
For student sponsored Aetna and Pacific Source Plans: we are ‘in network’ and will directly bill the insurance company. Your student account will only be billed for what is not covered by insurance.
For all other insurance plans*:* we bill any ‘out of network’ plan as a courtesy. The charges will first be applied to your student account. The insurance company may pay you directly, or if the company pays SHS directly we will subtract that amount from your student account.
For OSU Student Employee Worker’s Comp and Motor Vehicle Accidents: we will directly bill and accept payment in full from the covering insurance agency.

OREGON HEALTH PLAN: OSU Student Health Services is not a primary care provider for the Oregon Health Plan (OHP). OHP patients will be held financially responsible for any and all charges incurred at Student Health Services when they are not covered by OHP. You must notify Student Health Services immediately if you have applied for the Oregon Health Plan and are attempting to receive services at Student Health Services.

MEDICARE: OSU Student Health Services is not a service provider for Medicare patients.

PHOTO IDENTIFICATION: Your university photos will be incorporated into the SHS medical record for internal identification and safety purposes.

I have read and understand the above notifications.

To the best of my knowledge, the health and immunization history I have given is accurate. I understand that if this form is not completed within 6 weeks after my first date of attendance at OSU, a registration hold will be placed on my university account.

____

Student Signature | Printed Name | Date | Student ID #