BOWLING GREEN STATE UNIVERSITY
Student Health Service
Health Center Building
Bowling Green, Ohio 43403-0147
419-372-2271
Fax 419-372-8010
www.bgsu.edu/health

FOR CLINIC USE
ATTACH STUDENT INFORMATION LABEL

INTERNATIONAL HEALTH ASSESSMENT FORM

Instructions and Information - Important - Please Read!

1. Please return this form to the Student Health Service staff member at orientation.
2. All personal information should be filled out prior to visiting your Health Care Provider.
3. This form will become a part of the Student Medical Record and will be treated as per our Privacy Notice.

PLEASE TYPE OR PRINT

Name ______________________________ Home Phone ______________ Cell Phone ______________
Last First Middle Include Area Code

Home Address ____
Street City State Zip Code Country

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Other Date of Birth (00/00/00)______________ BGSU ID # ______________

Email Address ______________________________ Fax ______________________________

Citizenship: ☐ USA ☐ Other – Specify ____

Father's Name ______________________________ Mother's Name ______________________________

Address______________________________ Address ______________________________

______________________________ ______________________________
City State Zip City State Zip

Phone (H) ______________ (W) ______________ Phone (H) ______________(W) ______________

PRIMARY PERSON TO NOTIFY IN CASE OF AN EMERGENCY (Parent/Guardian)

Name ______________________________ Relationship ______________________________

Address ____
Street City State Zip Code Country

Home Phone ______________________________Business Phone ______________________________

Cell Phone ______________Fax ______________ Email address ______________________________

DISABILITY

If you consider yourself handicapped or disabled in any way please complete the following with specific information:

☐ Psychological ☐ Neurological ☐Hearing ☐ Pulmonary ☐Learning ☐ Mobility ☐ Other ______________

☐ None of the above

Explain ____

____

Medications

List all medications currently being taken with dosage, frequency and condition for which it is being taken:

MEDICATIONS	DOSAGE	FREQUENCY	DIAGNOSIS

Name ______________________ Date of Birth ______________________ BGSU ID # ______________________

ALLERGIES

Do you have allergies to any of the following? If so, describe reactions:

- ☐ Medications (please list) ______________________
- ☐ Immunizations (please list) ______________________
- ☐ Other ______________________
- ☐ None Known
- ☐ Anesthesia ______________________
- ☐ Foods ______________________
- ☐ Insect Stings ______________________
- ☐ Environmental (pollen, etc.) ______________________
- ☐ Latex ______________________

PLEASE LIST ALL MEDICAL PROBLEMS, TREATMENTS AND DATES:

____

____

PLEASE LIST ALL PAST ACCIDENTS, OVERNIGHT HOSPITALIZATIONS AND SURGERIES: (Please indicate dates.)

____

____

Have you ever experienced sexual, physical and/or emotional abuse? ☐ Yes ☐ No

Have you ever had to interrupt school or work for an extended period of time due to physical, emotional or mental illness? ☐ Yes ☐ No

If yes, please explain ______________________

FAMILY MEDICAL HISTORY

If any of your immediate family had/have the following, check the box indicating which family member it applies to:

	Father	Mother	Sibling	Grandparent		Father	Mother	Sibling	Grandparent
Alcohol/Drug Addiction					High Blood Pressure				
Cancer					Psychological Illness				
Diabetes					Died of heart attack under age 50				
Elevated Cholesterol					Stroke				
Heart Disease					Other				

Please comment on the health status of your immediate family, if known:

Family Member	Age	State of Health	Occupation (parents only)	Family Member	Age	State of Health
Father				Brother		
Mother				Sister		
Brother				Sister		
Brother				Sister		

NOTICE OF PRIVACY PRACTICES

For my review, I have been advised the Notice of Privacy Practices is located on the Student Health Service website at www.bgsu.edu/health. By signing this document I acknowledge that I will read the Notice of Privacy Practices.

I hereby authorize the BGSU Student Health Service for the purposes of communication by email. I understand that the Student Health Service does not have a secure, encrypted connection for email communication, and I have been advised the Secure Email Communication with Patients Policy is located on the Student Health Service website at www.bgsu.edu/health.

I hereby grant permission to the health care providers of Bowling Green State University Student Health Service, or another duly licensed healthcare facility, to evaluate, treat, or secure a referral to an outside agency in case of personal illness/injury.

______________________ ______________________ ______________________

Patient Signature | Printed Name | Date

PERMISSION FOR TREATMENT OF STUDENTS UNDER 18 YEARS OF AGE

Ohio state law requires us to contact a parent or legal guardian **before** providing routine medical care to a minor. However, to avoid delay in treatment when emergent medical problems arise, we request that the follow statement be signed by a parent or legal guardian. I hereby grant permission to the health care providers of Bowling Green State University Student Health Service, or anther duly licensed healthcare facility, to evaluate, treat or secure a referral to an outside agency for my son/daughter/ward in case of illness/injury. I also hereby grant permission to immunize my son/daughter/ward in cases where immunization is necessary as part of treatment plan or when needed for prevention of illness.

______________________ ______________________

Signature of Parent or Legal Guardian | Date

______________________ ______________________

Relationship to Student | Phone Number (include area code)

Name________________________________ Date of Birth____________ BGSU ID# ______________

BGSU®

IMMUNIZATION RECORD

Required by Ohio law and/or Bowling Green State University. Your signature is required in sections C & D.

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RECOMMENDED:
Fill in dates. Blood work documented immunity is acceptable only when immunization dates are unavailable.

A. M.M.R. (MEASLES, MUMPS, RUBELLA)
(Two doses required at least 28 days apart for students born after 1956)

1. Dose 1 Given at age 12 months or later ______/______/______
   Mo. Day Yr.

2. Dose 2 given at 28 days after first dose ______/______/______
   Mo. Day Yr.

B. TETANUS-DIPHTHERIA-PERTUSSIS
Last tetanus-diphtheria booster dose ______/______/______
Mo. Day Yr.

Type of Booster ☐ Td ☐ Tdap

C. Complete the MENINGITIS VACCINATION information below by checking the appropriate box.

☐ I have had the bacterial meningitis vaccine

Dose #1 ______/______/______
Mo. Day Yr.

Dose #2 ______/______/______
Mo. Day Yr.

☐ Menveo
☐ Menomune
☐ Menactra

☐ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine and have decided to decline vaccination at this time.

________________________________ ____________
STUDENT SIGNATURE DATE

________________________________ ____________
SIGNATURE OF PARENT OR LEGAL GUARDIAN DATE
If student is under 18 years of age.

D. Complete the HEPATITIS B information below by checking the appropriate box.

☐ Hepatitis B vaccine ☐ Combined Hepatitis A & B vaccine.

#1_____/_____/_____ #2_____/_____/_____ #3_____/_____/______
Mo. Day Yr. Mo. Day Yr. Mo. Day Yr.

☐ I have read, or have had explained to me, the information regarding Hepatitis B. I understand the risks of not receiving the vaccine and have decided to decline vaccination at this time.

________________________________ ____________
STUDENT SIGNATURE DATE

________________________________ ____________
SIGNATURE OF PARENT OR LEGAL GUARDIAN DATE
If student is under 18 years of age.

RECOMMENDED:

E. POLIO
Completed primary series of polio immunizations:

________/_______/_______
Mo. Day Yr.

F. HEPATITIS A

#1_______/_______/_______ #2________/________/_______
Mo. Day Yr. Mo. Day Yr.

G. CHICKENPOX (varicella) VACCINE

#1_______/_______/_______ #2_______/_______/_______
Mo. Day Yr. Mo. Day Yr.

History of Disease: Date _______/_______/_______
Mo. Day Yr.

H. HUMAN PAPILLOMAVIRUS (HPV) VACCINE
(Three doses of vaccine for female or male college students 11-26 years of age at 0, 1/2 and 6-month intervals.)

#1_____/_____/______ #2_____/______/______ #3_____/_____/_____
Mo. Day Yr. Mo. Day Yr. Mo. Day Yr.

☐ Bivalent (Cervorix) ☐ Quadrivalent (Gardasil)

I. TB SCREENING - REQUIRED
Tuberculosis (TB) Screening will be completed at the BGSU Student Health Service upon your arrival to campus. BGSU Student Health Service will not accept any previous TB test results.