



Enrollment Services
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International Student Health Information Statement

Section 1 – To Be Completed by the Student

Provide most recent dates for the following:

	Date:		Date:
Chest X-Ray		Tetanus-Toxoid Shot	
PPD Skin Test		Smallpox Vaccine	
		Diphtheria Toxoid	
		Polio Shot:	

Which one? (Circle) 1st 2nd 3rd 4th

Date of most recent **Physical Exam**: _____

Given by: _____ Where: _____

Date of most recent **Hearing Test**: _____ Type: _____

Results: _____

Complete the questions below based on your current health

	Yes	No		Yes	No	
Rheumatic Fever?			<div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;">Asthma, hay fever, eczema?</div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;">Food or drug sensitivity?</div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;">Chronic Nasal Discharge?</div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;">Diabetes?</div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;">Epilepsy?</div>			
Heart Disease?						
Tuberculosis?						
Measles?						
Dizzy Spells?						
Weakness or deformity of bones, joints or muscles?						
Do you have normal vision?				If no , explain:		
Do you have a health problem at the present time?				Explain:		
Have you ever had a serious health problem?						
Have you ever had a mental health problem?						
Are you restricted from participating in full physical activity?			If no , explain:			
Do you have normal hearing?			If no , explain:			

Continue to Section 2...

Section 2 – To Be Completed by the Physician

Applicant's name: _____

Deviations from normal in history or physical examination: _____

Urinalysis _____ **CBC:** Red _____ White _____ Hemoglobin
determination _____
Neg. or Pos.

H.I.V. Test _____ Serological test syphilis _____ Chest X-ray findings or PPD Skin Test _____
Neg. or Pos. Neg. or Pos.

Dates Immunizations given recently:

BCG. _____ Tetanus _____
Polio _____ Measles _____
Diphtheria _____ Other _____

Date of Examination

Signature of Physician (If other than doctor of medicine, please
indicate)