AMERICAN LANGUAGE & CULTURE INSTITUTE
ALCI CHICO

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International Student Health Certificate

Name (Last, First): _____ CSUC ID: _____

Date of Birth: _____ Gender (check box): ❑ Male ❑ Female
(Month / Day / Year)

The following to be filled out by Physician:

1. Measles/MMR Immunization

First Dose: _____ Second Dose (if any): _____
(Month / Day / Year) (Month / Day / Year)

Date of Disease (if applicable): _____ Date of Positive Serologic Test (if applicable): _____
(Month/Day/Year) (Month/Day/Year)

General Remarks on the Student's Health: _____

_____

Name of Clinic/Hospital: _____

Address of Clinic/Hospital: _____

_____

Signature of Physician (required): _____ Date: _____
(Month / Day / Year)

2. Tuberculin Examination (choose one of following)

___ a. Skin Test Results (cannot be older than 3 months before travel to U.S.)

- ❑ Positive (Please indicate the size of reaction): _____
- ❑ Negative–Revealed (No abnormalities)

___ b. Quantiferon Tuberculin Screen Test (cannot be older than 30 days before travel to U.S.)

- ❑ Positive
- ❑ Negative

*Important: Quantiferon test might be requested at the Student Health Center during the new student orientation with additional fee,*around $50. *(subject to change).*

___ c. No Tuberculin Examinations

General Remarks on the Student's Health: _____

_____

Name of Clinic/Hospital: _____

Address of Clinic/Hospital: _____

_____

Signature of Physician (required): _____ Date: _____
(Month / Day / Year)