International Student Health Certificate

Name (Last, First) ________________________________

Date of Birth: ________________________________ Gender (check box): [ ] Male [ ] Female

(Month/Day/Year)

The following to be filled out by a physician:

1) Measles/MMR Immunization

First Dose: ________________________________ Second Dose (if applicable): ________________________________

(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) Hepatitis B (3 shot series) (If you are 18 years or younger on the first day of classes)

(month/day/year) (month/day/year) (month/day/year)

Name of Clinic/Hospital: ________________________________________________________________

Address of Clinic/Hospital: ________________________________________________________________

Signature of physician (required): ________________________________ Date: ________________________________

3) Tuberculin Examination (Choose one of the following)

_____ a. Skin Test Results (cannot be older than 90 days 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 90 days before travel to U.S.):

[ ] Positive

[ ] Negative

**Important:** Quantiferon test might be requested at the Student Health Center during the new student orientation for an additional $55 fee. (Amount subject to change)

_____ c. No Tuberculin Examinations (cannot be older than 90 days before travel to U.S.):
General Remarks on the Student’s Health:

Name of Clinic/Hospital: ________________________________
Address of Clinic/Hospital: ________________________________

Signature of physician (required): __________________________ Date: ________________________________ (Month/Day/Year)

Revised: November 2019