



International Student Visa Program Health Form

Please submit a completed form with your application materials. Health forms must be signed by a physician.

Student Information: (please print clearly and keep a copy of this form for your records)

Today's Date _____ Expected Enrollment Date _____

Student's Name _____ Male _____ Female
Last First Middle
_____ Single _____ Married

Local Address _____
Street
_____ City State Postal Code

Home Phone Number _____ Date of Birth _____
month/day/year

Parents Name _____

Parents Address _____
City State Postal Code Country

In Case of Emergency Notify _____
Relationship to Student _____

Medical History

List any medical conditions you have including asthma, high or low blood pressure, heart conditions, allergies etc.

List any medications that you take regularly. Please include birth control pills, vitamins and minerals.
(We recommend that you bring what you anticipate needing, or a written prescription from your physician)

Nonprescription _____
Prescription _____

List any allergies or reactions you have had to medications.

Medication	Reaction	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any allergies or reactions you have to foods, molds, pollens animals, insects, etc.

List any physical or dance related problems you have including injuries, bone, joint, or muscular disorders, etc.

Have you ever been hospitalized? Yes ____ (If yes, please specify below including dates) No ____

Physical Illness _____

Injury _____

Surgery _____

Psychiatric _____

One's emotional life often has an effect directly or indirectly, on one's physical health, such as symptoms of stress or mood changes. Please provide information about any psychological or emotional matters which could affect your physical health, about which our School should be aware.

Have you been vaccinated for the following: Chicken Pox ____ Measles ____

Do you have any religious beliefs affecting any aspect of your health care about which our School should know?
Yes _____ (If yes, please specify below) No _____

Health Insurance Information

Do you currently have health insurance coverage? Please provide information below.

Health Insurance Company _____ Dates of Coverage _____
(please include with this application a copy of your health insurance card or other confirmation of insurance)

Please list your doctor's information below (including any health care providers in addition to your primary care physician, including chiropractors, Physical therapists, etc.)

Primary Physician _____ Telephone _____

Other Health Care Providers _____ Telephone _____

I, _____, confirm that the information provided is correct and true.

Student's Signature Date

Doctor's Signature(required) Date

Doctor's Address and telephone number
