

University of Wisconsin – Platteville International Student Health Form



To be collected at international student orientation.
Or, you may send the completed form to: UW-Platteville Student Health Services,
216 Royce Hall, 1 University Plaza, Platteville WI 53818-3099.
For questions, call 608.342.1891 or email dreessev@uwplatt.edu

Student Identification

Family/Surname _____ First Name _____

Mailing address _____

City _____ State/Province _____ Country _____ Mail Code _____

Telephone number _____

Email address _____

Person to notify in case of emergency

Name _____

Mailing address _____

City _____ State _____ Country _____ Mail Code _____

Telephone number _____

Email address _____

Immunization Information

MMR (Measles, Mumps, Rubella)

Dose 1 – Immunized at 12 months or after and before 5 years Enter date _____

Dose 2 – Immunized at 5 years or later Enter date _____

If you did not received the MMR, please respond to this section

Measles (Rubeola) – if given instead of MMR. Check appropriate box, please.

Had disease; confirmed by office record Date _____

Had report of immune titer. Specify date of titer Date _____

Immunized with live measles vaccine at 12 months after birth or later Date _____

Rubella (German measles) – if given instead of MMR. Check appropriate box, please

Had report of immune titer. Specify date of titer Date _____

Immunized with vaccine at 12 months after birth or later Date _____

Mumps – if given instead of MMR. Check appropriate box, please.

Had disease; confirmed by office record Date _____

Immunized with vaccine at 12 months after birth or later Date _____

Tetanus-Diphtheria Date of last shot _____

(NOTE: If last shot was administered over 10 years ago, a booster shot is needed.)

Tuberculosis – Check appropriate box

PPD (Mantoux) text within the past year Date _____

If PPD was positive, a chest x-ray is required Result Positive Negative Date _____

Result _____

Other recommended immunizations

Hepatitis B

	Date	Dose
1.	_____	_____
2.	_____	_____
3.	_____	_____

Varicella (Chickenpox)

	Date
1.	_____
2.	_____

Menomune/Menactra

	Date
1.	_____

Please complete the following

Have you ever experienced (please check)	Yes	No		Yes	No
1. Allergies			12. Digestive problems (ie, ulcers, colitis)		
2. Allergies to medications – please list below			13. Nutrition/weight concerns		
3. Hospitalization/Surgery			14. Genital/Urinary (ie, pregnancy, STD)		
4. Cancer			15. Musculoskeletal (ie, back, neck, knee)		
5. Diabetes			16. Blood disorders (ie, clots)		
6. Thyroid disease			17. Dermatology (ie, acne, eczema)		
7. Heart disease			18. Sexual assault		
8. Neurological issues (ie, headaches, seizures)			19. Smoking/Chewing		
9. Mental health issues (ie, depression, anxiety)			20. Drug addiction		
10. Respiratory problems (asthma, bronchitis)			21. Disability (a condition requiring special consideration) – please explain below		
11. Alcohol abuse					

Please use the following space to provide additional information about items where response was yes:

Please list medications you take on a frequent or regular basis (includes vitamins, birth control pills, aspirin):

The following should be completed by a licensed health care provider

Physical Examination	Date of Examination _____
Name of person examined _____	
Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth _____
Height _____ Weight _____	Blood Pressure _____ Radial Pulse _____
HEENT:	Assessment/Exam finding:
NECK:	
HEART:	Do you have any recommendations regarding care of this student while attending the university? <input type="checkbox"/> None <input type="checkbox"/> Yes
LUNGS:	
BREASTS:	Activity Restrictions: <input type="checkbox"/> None <input type="checkbox"/> Yes
ABDOMEN:	Please list restrictions
GENITO/URINARY:	Other comments _____
MUSCULOSKELETAL:	
NEURO-PSYCH:	Signature of Examiner _____
PELVIC (optional):	Examiner's Name (Printed) _____
Any other pertinent findings:	Clinic Name _____
	Clinic Address _____
	Clinic Telephone/Email _____