

PLEASE USE INK AND PRINT. PLEASE ANSWER ALL QUESTIONS.

Name: _____

Date of Birth: _____

Immunizations: The following immunizations/tests are **required**. The form must be signed by a Health Care Professional, OR have a Health Department stamp, OR a photocopy of official immunization records can be attached.
(WE WILL NOT ACCEPT DATES WRITTEN IN WITH NO PROOF.)

Required of All Students: Tuberculosis screening: PPD required regardless of prior BCG inoculation. The test must be within ONE YEAR prior to enrollment at CIU.

Date given: _____ Date read: _____ Result (report actual mm): _____ Negative Positive
T-Spot blood test allowed. Provide copy of report.

Chest X-ray required for positive TB test.

X-Ray result: Normal: _____ Abnormal: _____ Date: _____ Provide copy of report.

Required if Born After 1956:

MMR (Measles, Mumps, Rubella): Two doses given after first birthday (30 or more days apart).

#1: _____ / _____ / _____
(MO/DAY/YR)

#2: _____ / _____ / _____
(MO/DAY/YR)

OR

Rubeola (Measles): Two doses required after 1967 and after first birthday (30 or more days apart). Immunity confirmed by blood titer also accepted. **Copy of lab report required.**

#1: _____ / _____ / _____
(MO/DAY/YR)

#2: _____ / _____ / _____
(MO/DAY/YR)

Copy of immune blood titer result enclosed _____

AND

Rubella (German Measles): One dose required after 1967 and after first birthday. Immunity confirmed by blood titer also accepted. **Copy of lab report required.**

#1: _____ / _____ / _____
(MO/DAY/YR)

Copy of immune blood titer result enclosed _____

Optional Immunizations (recommended): — Please Document Dates —

1. Hepatitis B Vaccine Series: Dose #1 _____ Dose #2 _____ Dose #3 _____

2. Meningitis Vaccine: Name of Vaccine _____ Date Given _____

3. Polio: Completed primary series of polio immunization: Yes _____ No _____

4. Tetanus Diphtheria-Pertussis: Booster within the past 10 years (provide date given): Tdap _____ or Td _____

5. Varicella (chicken pox)

a.) History of disease: Date _____

b.) If you have never had the disease or are unsure, vaccination is recommended. Dose #1 _____ Dose #2 _____

PHYSICIAN'S SIGNATURE OR HEALTH DEPARTMENT STAMP

OFFICE PHONE NUMBER

DATE

(Please continue form on other side.)

Medical History/Information

Height: _____ Weight: _____

Entering Date: _____ Readmit: Yes No

Name: _____ Date of Birth: _____ Sex: _____

Social Security Number: _____ Phone: _____

Permanent Address: _____

Please Check All That Apply:

- | | | |
|----------------------------------------------|---------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> ASTHMA | <input type="checkbox"/> BACK PROBLEMS |
| <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> DIABETES | <input type="checkbox"/> EAR TROUBLE |
| <input type="checkbox"/> EYE TROUBLE | <input type="checkbox"/> EPILEPSY/SEIZURES | <input type="checkbox"/> FREQUENT ANXIETY |
| <input type="checkbox"/> HAY FEVER | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> HEART MURMUR |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> INFECTIOUS MONONUCLEOSIS | <input type="checkbox"/> INJURY TO BONE/JOINTS |
| <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> MALARIA | <input type="checkbox"/> MIGRAINE HEADACHES |
| <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> SICKLE CELL DISEASE | <input type="checkbox"/> STOMACH/INTESTINAL TROUBLE |
| <input type="checkbox"/> THYROID PROBLEMS | <input type="checkbox"/> TUBERCULOSIS | |

Please list any other information not covered above (operations, hospitalizations, etc.)

Allergies: (Medications, foods, insect bites, etc.) Please be specific as to what allergic response you have (rash, breathing problems, etc.)

Current Medications:

Medical Insurance

All students are required to have accident and hospitalization insurance. Please attach a copy of your insurance card (front and back) to this form. Every U.S. citizen is required by the federal government to have medical insurance coverage or a fine will be assessed when completing your federal income tax forms. If you currently do not have insurance coverage, you will need to purchase a policy and provide that information to CIU Health Services before beginning your courses. Information for purchasing insurance can be found by going to the MyCIU Student Home Page > Insurance.

International Students: information for purchasing insurance can be found on the same page but look for the special "International Student Insurance" heading.

*** Students with chronic illness requiring in-depth medical care and follow-up must make arrangements with a local physician.*

The information you provide on this form is strictly for the use of Health Services to assist in providing health care while you are a student. It will not influence your admission status, and will not be released to an unauthorized person without your consent.

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name: _____

Relationship: _____

Address: _____

Phone: _____

PLEASE RETURN FORM TO:

CIU Admissions
7435 Monticello Road
Columbia, SC 29203

Phone: (803) 807-5024
Fax: (803) 223-2500
Attention: Admissions

DEADLINE:

Undergraduate School:
Fall Registration: July 1
Spring Registration: December 15

Graduate School/Seminary:
Fall Registration: August 1
Spring Registration: December 15