

Columbia International University

Pre-Registration Medical Requirements

PLEASE RETURN FORM TO:
 CIU Health Services
 7435 Monticello Road
 Columbia SC 29203
 03 754 4100 Ext 3056
 Fax: 03 7 6 4209
 Attention: Health Services

EA LINE:

Bible College:

June 1 for Summer Orientation 1
 July 1 for Summer Orientation 2
 August 1 for Fall Registration
 December 15 for Spring Registration

Graduate School/Seminary:

August 1 for Fall Registration
 December 15 for Spring Registration

► 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. Tine test not accepted. The test must be within **ONE YEAR** prior to enrollment at CIU.

Date given: _____ Date read: _____ Results (mm,): _____

If PPD is positive a chest X-Ray is required. Positive ppd date: _____

X-Ray result: Normal: _____ Abnormal: _____ Date: _____

Required if Born After 1956:

Exempt if pregnant/pregnancy possible within 90 days — if so please check here _____

MMR (Measles Mumps Rubella,): Two doses given after first birthday (0 or more days apart,.

•) : $\frac{\quad}{(MO/DAY/YR,}$ X : $\frac{\quad}{(MO/DAY/YR,}$
OR

Rubeola (Measles,): Two doses required after , 967 and after first birthday (0 or more days apart,. Immunity confirmed by blood titer also accepted. Copy of lab report required.

•) : $\frac{\quad}{(MO/DAY/YR,}$ X : $\frac{\quad}{(MO/DAY/YR,}$

Copy of immune blood titer result enclosed _____

AND

Rubella (German Measles,): One dose required after , 967 and after first birthday. Immunity confirmed by blood titer also accepted. Copy of lab report required.

•) : $\frac{\quad}{(MO/DAY/YR,}$
 _____ Copy of immune blood titer result enclosed

Optional: Immunizations (recommended but not required,:

•) Hepatitis B Vaccine Series: Dose , _____ Dose X _____ Dose , _____

X Meningococcal Vaccine date of dose _____

• Polio: Completed primary series of polio immunization: Yes _____ No _____

4. Tetanus Diphtheria: Booster within the past , 0 years:
 Tetanus Toxoid _____ or Tetanus diphtheria _____

5. Varicella (chicken pox,
 a, History of disease: Date _____

b, If you have never had the disease or are unsure vaccination is recommended. Dose , _____ Dose X _____

 PHYSICIAN'S SIGNATURE OR HEALTH DEPARTMENT STAMP OFFICE PHONE NUMBER DATE

Pre-Registration Medical Requirements

PLEASE USE INK AND PRINT PLEASE ANSWER ALL QUESTIONS

Medical History/Information:

HEIGHT _____ WEIGHT _____

ENTERING DATE: _____ READMIT: YES NO

NAME: _____

DATE OF BIRTH: _____ SEX: _____

SOCIAL SECURITY NUMBER: _____ PHONE: _____

PERMANENT ADDRESS: _____

PLEASE CIRCLE ALL THAT APPLY:

ANEMIA

ASTHMA

BACK PROBLEMS

DEPRESSION

DIABETES

EAR TROUBLE

EYE TROUBLE

EPILEPSY/SEIZURES

FREQUENT ANXIETY

HAY FEVER

HEPATITIS

HEART MURMUR

HIGH BLOOD PRESSURE

INFECTIOUS MONONUCLEOSIS

INJURY TO BONE/JOINTS

KIDNEY DISEASE

MALARIA

MIGRAINE HEADACHES

RHEUMATIC FEVER

SICKLE CELL DISEASE

STOMACH/INTESTINAL TROUBLE

THYROID PROBLEMS

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. If you do not have insurance coverage you may enroll in the CIU student insurance plan by contacting the Benefits office in the Administration Building (80 -754-4, 00 ext. 0, 5,.

Enclosed is a copy of my Insurance card.

I intend to purchase the school insurance. (Checking this does not register you for the insurance. You will need to enroll and pay for the insurance at registration., See www.ciu.edu for more information.

*** 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: _____