CIU Columbia International University

Pre-Registration Medical Requirements Form

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:

☐ 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. 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