ROBERTS WESLEYAN COLLEGE

International F-1 Visa Form for College Attendance

New or Transfer Full-time Undergrad Students with 6 credit hours or more

Please check all that apply: Year: 2 ________ ❑ Fall semester ❑ Spring semester ❑ Summer semester ❑ Please list sport(s) ______________________ ❑ Undergraduate Freshman ❑ Transfer Student ❑ International Student ❑ E.L.I. Student ❑ B.E.L.L. Student	*Failure to comply with the New York State Public Health Law 2165 and 2167 regulations prevent clearance for attendance.* To secure and maintain confidentiality, please submit the completed form and documents directly to the: 1. Mail to Health Center Roberts Wesleyan College 2301 Westside Drive, Rochester, NY 14624 2. Email at healthcenter@roberts.edu 3. Fax (secured line) at 585-594-6920 Incomplete or unsigned forms will not be processed.	**Office Use Only** **Received:** ______________ **Cleared by:** ______________ **Date:** ______________ **DEADLINE Date:** One month prior to first class session or sport participation. Early submission will expedite attendance compliance process.

Last name: ______________________ First: ______________________ Middle Intial:_____

Date of birth: (MM-DD-YY) ____/____/____ Sex: M ❒ F ❒ Citizenship: U.S. ❒ Other ❒ (specify) ____________

Address: (street/PO box) ____

City/Town: ______________________ State: ____Zip: _________ Home Phone:(____)_____-_________

Cell Phone: (____) _____- _________ Email Address: ______________________________

INSURANCE INFORMATION: A copy of insurance card is required.

Last: (Primary) ______________________ First:______________________ Middle Initial: _____

Relationship to student: _______________ Primary's DOB: _____/_____/_____ Primary's Gender:________

Insurance Company:____

Policy No:______________________ Group No:______________________

Effective Date: _____/_____/_____ Termination Date: _____/_____/_____

RELEASE OF INFORMATION / EMERGENCY CONTACT:

I give permission to the Health Center staff at Roberts Wesleyan College to discuss my health care with the individual indicated below. I also authorize this person to be called in case of an emergency.

Name: ______________________________________ Relationship: ________________

Daytime phone #: ______________ Evening Phone #: ______________ Cell phone #: ______________

Student's signature: (required) ______________________________ Date: _____/_____/_____

AUTHORIZATION FOR TREATMENT

In submitting this Health History Form, I attest the information is complete and accurate. I authorize Roberts Wesleyan College Health Center to provide medical treatment and services as they deem appropriate. I understand the information may be shared with the Athletic Department, Campus Security, Counseling Center and/or Learning Center staff as/if needed, in order to facilitate collaboration among campus services for my comprehensive health care.

I understand that my medical records are confidential and maintained separately from my academic records. To have my medical records shared with others requires my written permission except in the event of a life-threatening and/or serious illness or injury of which the Health Center is aware, parents(s) or guardian may be notified at the discretion of the professional staff. *This authorization for treatment is active for the duration I am a student at Roberts Wesleyan College.*

Student's signature: (required) ______________________________ Date: _____/_____/_____

Parent's signature: (required if student is under age 18) ______________________ Date: _____/_____/_____

General History: To be completed by the student and/or parent/guardian(s)

Please give details below for any "yes" answers

Have you had:	Y	N		Y	N		Y	N		Y	N
ADD/ADHD			Depression			Impaired Vision			Thyroid Disease		
Alcohol/Drug Dependency			Diabetes			Irritable/spastic bowel			Tuberculosis		
Anemia			Disease/Injury of Joints			Kidney Disease			Ulcerative Colitis		
Anger Issues			Seizure disorder (specify below)			Kidney Infection			Urinary Tract Infections		
Anorexia Nervosa			Ear/Nose/Throat Problems			Kidney Stones			Venereal Disease		
Anxiety			Endocrine/Metabolic Disorder			Malaria			Weight Loss/Gain		
Arthritis (specify below)			Fainting			Measles (specify below)			Allergy To:		
Asthma			Fractures (specify below)			Mononucleosis			Penicillin		
Back Problems			Frequent Colds or Sinusitis			Mumps			Sulfonamides		
Bipolar Disorder			Gall Bladder Disease			Orthopedic Problems			Other (specify below)		
Blood Disorders (specify)			Gastrointestinal/GERD/Reflux			Recurrent Headaches			Food (specify below)		
Bulimia			Head Injury (Serious/Unconscious)			Rheumatic Fever					
Cancer			Heart Murmur			Rubella (German Measles)			Surgery:		
Cerebral Palsy			Heart Palpitations			Scarlet Fever			Appendectomy		
Chicken Pox			Hepatitis (specify below)			Seasonal Allergies			Tonsillectomy		
Convulsive Disorder			Hernia			Self-harming Behavior			Wisdom Teeth Removed		
Crohn's Disease			High Blood Cholesterol			Skin Conditions			Other (specify below)		
Cystic Fibrosis			High Blood Pressure			Sleep Disorder			Last Dental Exam Date		
Cystitis/bladder Infection			Impaired Hearing			Suicidal Thought/Attempts					

Comments and/or explanation(s):

Medical History (Answer all questions)	Yes	No	Explain all "yes" answers below or on an additional sheet and attach.
Do you have any drug/medication allergy?			
Do you smoke?			
Do you consume alcohol?			
Do you use recreational drugs?			
Has your physical activity been restricted during the past five years?			
Have you had any illness or injury or been hospitalized other than already noted above?			
Do you have an ongoing health problem that has required treatment by a physician or other health care provider in the past five years?			
Have you received treatment by a psychiatrist or clinical psychologist?			
Do you take medication on a regular basis? If so, please list name(s) and dosage(s).			
Do you consider yourself challenged or disabled in any way that requires you to receive special consideration from RWC? If so, please specify.			

Examination: ***(to be completed and signed or attached copy of the medical provider's record)***

Name: ____ **Physical Date:** ______/______/______

Height: _______ **Weight:** _______ **BP:** _______ **Pulse:** _______ **Vision: L 20/**______ **R 20/** _______

	No	Yes	Note variances, abnormal or significant findings
General			
HEENT			
Neck/Endocrine			
Respiratory			
Cardiovascular			
Breast			
Abdomen			
Genitourinary			
Hernia			
Neurologic			
Skin			
Musculoskeletal			
Neck/Shoulder/Arm			
Wrist/Hand/Fingers			
Hip/Thigh/Knee			
Leg/Ankle/Foot			

Does the student have drug allergies? If yes, please list by name and type of reaction: ______________________________

____

Recommendations/Comments regarding the chronic condition or serious illness continuing care of the student:

____

____

Recommendations/Comments regarding the emotional, continuing care of the student:

____

____

Medically cleared to participate in a full program of college study: _____Yes _____ No

Medically cleared for intercollegiate athletic participation: _____Yes _____ No

Limitations/Comments: ____

Medical provider signature/stamp or a copy of the medical provider's document must be attached. **STAMP**

____

MD, NP, or PA's Signature:

____

MD, NP, or PA's Printed Name:

____

Address, City, State:

Immunization Record: ***(must be completed and signed or attach copy of the medical provider's record)***

Student's Name: ____ **Date of Birth: ______/______/______**

REQUIRED

Records of the following are REQUIRED for International (F-1) Students attending Roberts Wesleyan College:

1. NYS Public Health Law 2165 & 2167 mandates students born after January 1, 1957 enrolled in six (6) credit hours or more to provide documented proof of immunity (vaccines or positive titer (blood test) results against measles, mumps, rubella and meningococcal meningitis disease:

Must fully complete ONE of the following three options:	
Option 1	**MMR #1 (Measles, Mumps, Rubella) Date: ______/______/______** **MMR #2 (Measles, Mumps, Rubella) Date: ______/______/______**
Option 2	**Measles #1 (Rubeola) Date: ______/______/______** **Measles #2 (Rubeola) Date: ______/______/______** **Mumps Date: ______/______/______** **Rubella (German measles) Date: ______/______/______**
Option 3	**Positive Measles Titer Date: ______/______/______** **Positive Mumps Titer Date: ______/______/______** **Positive Rubella Titer Date: ______/______/______**

2. NYSPHL Law 2167 mandates ALL students, regardless of age, to provide either proof of meningococcal vaccine or a signed declination statement rejecting the meningococcal vaccine.

Must fully complete ONE of the following two options:	
Option 1	**Meningococcal Vaccine Type: ___________________________** **Date: ______/______/______ (dated within 5 years)**
Option 2	***Student elected not to be immunized against meningococcal meningitis disease.*** **I have read or have had explained to me the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I decided NOT to be immunized against the meningococcal meningitis disease.** **Student's Signature: ____ Date:______/______/______**

3. Tuberculosis Screening (dated within one year)

Must fully complete	
ONLY Option	**PPD (Mantoux) within the past year:** **Date placed: ____/____/____ Date read: ____/____/____ (within 48-72 hours)** RESULT: ____ Negative ____ Positive _______ mm indurations *(If positive, chest x-ray report is mandated)*

Medical provider signature/stamp or a copy of the medical provider's document must be attached.

____
MD, NP, or PA's Signature:

____
MD, NP, or PA's Printed Name:

____
Address, City, State:

STAMP

Immunization Record: ***(must be completed and signed or attach copy of the medical provider's record)***

Student's Name: ____ **Date of Birth:** ______/______/______

RECOMMENDED

The following immunizations are suggested for International (F-1) Students attending Roberts Wesleyan College:

Tetanus/Diphtheria/Pertussis	**Date:** ______/______/______ **(dated within 10 years)**		
Hepatitis A	**#1 Date:** ____/____/____ **#2 Date:** ____/____/____	**OR**	**Positive Titer Date:** ____/____/____
Hepatitis B	**#1 Date:** ____/____/____ **#2 Date:** ____/____/____ **#3 Date:** ____/____/____	**OR**	**Positive Titer Date:** ____/____/____
Polio Booster	**Date:** ____/____/____		
Seasonal Flu vaccine	**Date:** ____/____/____		
Varicella	**History of Varicella disease: Yes** _____ **No** _____ **Date:** ____/____/____ **#1 Date:** ____/____/____ **#2 Date:** ____/____/____	**OR**	**Positive Titer Date:** ____/____/____

Medical provider signature/stamp or a copy of the medical provider's document must be attached.

____

MD, NP, or PA's Signature:

____

MD, NP, or PA's Printed Name:

____

Address, City, State:

STAMP