Columbia International University
Est. 1923
"To know Him and to make Him known"

# Pre-Registration Medical Requirements

**PLEASE RETURN FORM TO:**

**CIU Health Services**
**7435 Monticello Road**
**Columbia, SC 29203**
**Ph.: 803.807.5056**
**Fax: 803.786.4209**
**Attention: Health Services**

**DEADLINE:**

***Undergraduate School:***
*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: _____ Result (report actual 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 (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: Menactra _____Menomune _____
3. Polio: Completed primary series of polio immunization: Yes _____ No _____
4. Tetanus Diphtheria-Pertussis: Booster within the past 10 years:
   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.*

# 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 at registration. For more information, go to www.ciu.edu.

○ Enclosed is a copy of my Insurance card.

○ I intend to purchase CIU student insurance. (Checking this does not register you for the insurance. You will need to enroll on the CIU Online Registration Check-in page.)

*** 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 CONTINUE FORM ON OTHER SIDE.*