

International Student Health Form

(Please complete this form in English)

Student's Name: _____
(Last or Family Name) (First) (Middle)

Mailing Address: _____

Telephone #: _____ **Date of Birth:** _____
(Month/Day/Year)

Emergency Contact Information

Name: _____ **Relationship:** _____

Address: _____ **Telephone #:** _____

_____ **Fax #:** _____

_____ **E-Mail:** _____

To be completed by Physician

Immunizations *(Required by Montana State Law):*

Minimums:

Diphtheria and Tetanus (DT) last immunization after 4th birthday)

2 Doses—Measles/Mumps/Rubella (MMR) after 1st birthday

1—Tuberculosis Skin Test (Within 12 months of requested admission term)

(Please indicate Month/Day/Year (MM/DD/YY) for school audit purposes)

Completed	Dose 1	Dose 2
DT	_____	_____
MMR	_____	_____
TB Test	Date: _____	Result: (Circle One) Negative Positive

Physician's Name (Printed in English): _____

Physician's Address: _____ **Telephone #:** _____

_____ **Fax #:** _____

Physician's Signature: _____ **Date:** _____