Asheville Christian ACADEMY

Health Records for International Student Application for Admissions

Please direct all application materials to:
International Admissions/Program Coordinator
PO Box 1089
74 Riverwood Rd
Swannanoa, NC 28778
828.581.2208
brenton.benware@ashevillechristian.org

Part I: Student Information

Student's Full Legal Name: _____
Last *First* *Middle*

Gender: ☐ Male ☐ Female Date of Birth: ____/____/____
Month *Day* *Year*

Student's Home Address _____
Street/Building

_____
City *State/Province* *Postal Code* *Country*

_____ _____
Home Phone *Parent Mobile Phone*

Part II: Medical History *(to be completed by a physician in consultation with the student)*

Important: Physician, this student is considering a year or more abroad as an international student. Insufficient,inadequate, or improper information about medications or psychiatric, psychological, or other medical conditions could endanger the student's life while overseas. Allergy information is especially crucial to host family placementand student well-being. An immediate relative of the student may NOT complete the examination or fill out this form.

Height: _____ **Weight**: _____

1. How long has the student been your patient? _____
2. Has the student ever been diagnosed with or received advice for the following allergies?

a. Aspirin	Yes	No	d. Insect stings/bites	Yes	No	g. Other _
b. Food	Yes	No	e. Penicillin	Yes	No	
c. Hay Fever	Yes	No	f. Poison Ivy/Oak	Yes	No	

If any of the answers above are "Yes," please explain the nature and severity of the disorder, diagnosis,frequency of attacks, and treatment dates and duration (please attach additional pages if necessary):

_____

_____

_____

_____

_____

_____

_____

Part II: Medical History (Continued)

3. Has the student ever been diagnosed with or received treatment or advice for any disease orabnormality of any of the flowing? (Please circle if "Yes"):

a. Altitude sickness
b. Anorexia/eating disorder
c. Appendicitis
d. Arthritis
e. Asthma
f. Autoimmune disease
g. Blood or Endocrine system
h. Bones/joints
i. Bowel problems
j. Brain/nervous system
k. Cancer
l. Communicable disease
m. Depression
n. Diabetes
o. Ears/hearing
p. Eyes/vision
q. Epilepsy
r. Genito-urinary system
s. Heart disease
t. Hernia
u. Hypertension
v. Liver/hepatitis
w. Respiratory system
x. Malaria
y. Menstrual disorders
z. Mental/emotional disorders
aa. Pneumonia
bb. Scarlet fever
cc. Seizers
dd. Serious headache
ee. Serious or persistent cough
ff. Skin
gg. Stomach/digestive system
hh. Tonsils, nose, or throat
ii. Typhoid fever
jj. Vertigo/dizziness
kk. Other

Please explain the nature and severity of disorder, diagnosis, frequency of attacks, and treatment dates andduration of any circled answers (please attach additional pages if necessary):

_____

_____

_____

_____

_____

4. Has the student:

A. Had any surgical operation not revealed in question 2 or 3 or been hospitalized or treated for any other condition not revealed in question 2 or 3? ☐ Yes ☐ No

B. Taken any prescribed medication in the past six months: ☐ Yes ☐ No

C. Ever used heroin, cocaine, marijuana or other hallucinogens, amphetamines, or otherstreet drugs? ☐ Yes ☐ No

D. Ever received treatment for or advice about a problem with alcohol or drug use, either from a physician/other practitioner or an organization that assists those who have an alcohol or drug problem? ☐ Yes ☐ No

E. Had excessive weight gain or loss recently? ☐ Yes ☐ No

F. Had any dietary restrictions for medical, religious, or personal reasons? ☐ Yes ☐ No

G. Had any psychological problems? ☐ Yes ☐ No

H. Had any injury that would prevent them from participating in sports? ☐ Yes ☐ No

Please explain any "Yes" answers below (please use additional paper if needed):

_____

_____

_____

_____

5. Will the student be bringing any prescribed medications to the host country? ☐ Yes ☐ No

If "Yes" please list each medication, including international and generic names, compound symbols, dosage,frequency, and reason for use:

Prescription Medication	Dose/Frequency	Reason for Use

6. The student must present evidence of recent (within 3 months) screening:

Tuberculosis screening: Date _____

Mantoux tuberculin skin test result/diagnosis OR QuantiFERON-TB Gold Test result/diagnosis:

_____

Has the student ever been treated for tuberculosis? ☐ Yes Date(s)_____ ☐ No

If "Yes," please explain the treatment method: _____

Has the student ever received a BCG vaccine? ☐ Yes Date(s)_____ ☐ No

Result of chest x-ray:_____ Date _____
(mo/day/yr)

I certify that I hold a valid current license to practice medicine and am not an immediate relative of the patient. I certify that I have personally examined the student and reported my findings as noted above. I further state that all the information I have supplied is true and accurate to the best of my knowledge.

Printed Name of Physician: _____

Physician's Signature: _____
Date (mo/day/yr)

Physician's Address _____
Street/Building

_____
City *State/Province* *Postal Code* *Country*

_____ _____
Office Phone *Mobile Phone*

_____
Physician's Email Address

Asheville Christian ACADEMY

Immunization/Inoculation Record

(Please print clearly in ink)

Student's Full Legal Name: _____
Last *First* *Middle*

Gender: ☐ Male ☐ Female Date of Birth: _____/_____/_____
Month *Day* *Year*

Type of vaccineand number of required doses	1st Dose mo/day/year	2nd Dose m/d/y	3rd Dose m/d/y	4th Dose m/d/y	5th Dose m/d/y
Polio (4)					
DPT (5)					
Measles (2)					
Rubella (2)					
Mumps (2)					
Hepatitis A (1)					
Hepatitis B (3)					
Varicella (1) (Chicken pox)					
Tdap Booster (1)					
Meningococcal Conjugate (1)					
Other (specify)					

Other comments: _____

Printed Name of Physician: _____

Physician's Signature: _____
Date (mo/day/yr)

Immunization Requirements are subject to change. In the event that North Carolina health authorities determine that the above student requires further immunization, I give permission for the above student to be further immunized:

Parent's signature: _____
Date (mo/day/yr)

Asheville Christian Academy

Dental Health and Examination

(Please print clearly in ink)

Part I: Student Information

Student's Full Legal Name: _____
Last *First* *Middle*

Gender: ☐ Male ☐ Female Date of Birth: ____/____/____
Month *Day* *Year*

Student's Home Address _____
Street/Building

_____
City *State/Province* *Postal Code* *Country*

_____ _____
Home Phone *Parent Mobile Phone*

Part II: Dental Examination *(to be completed by a dentist in consultation with the student)*

Important: Dentist, this student is considering a year or more abroad as an international student. Insufficient, inadequate, or improper information about medications or other medical conditions could endanger the student's lifewhile overseas. Allergy information is especially crucial to student well-being. An immediate relative of the student may NOT complete the examination or fill out this form.

1. Is the student in good dental health? ☐ Yes ☐ No
2. Does the student require any dental work at this time? ☐ Yes ☐ No
3. Do you foresee the student requiring any dental work while in the United States? ☐ Yes ☐ No
4. Does the student have any known allergies to products commonly used in dentistry? ☐ Yes ☐ No ☐ None Known

Please explain if you have answered "Yes" to any of the above questions: _____

_____

_____

I certify that I hold a valid current license to practice dentistry and am not an immediate relative of the patient. I certify that I have personally examined the student and reported my findings as noted above. I further state that allthe information I have supplied is true and accurate to the best of my knowledge.

Printed Name of Dentist: _____

Dentist's Signature: _____
Date (mo/day/yr)

Dentist's Address _____
Street/Building

_____
City *State/Province* *Postal Code* *Country*

_____ _____
Office Phone *Mobile Phone*

_____
Dentist's Email Address