LARAMIE COUNTY COMMUNITY COLLEGE

1400 East College Drive | Cheyenne, Wyoming 82007 | 800.522.2993 | lccc.wy.edu

International Student Health Form

To be completed by the student if 21 years or older – otherwise, to be completed by parent or guardian.

Name: Last (family)	First (given)	Middle
Phone Number:	**Date of Birth:** (mm/dd/yy)	
Permanent Address: Street/PO Box	City, State, ZIP, Country (if not USA)	
Person to be notified in an emergency: Name	Phone Number	
Family Physician: Name	Phone Number	
Address: Street/PO Box	City, State, ZIP, Country (if not USA)	

STUDENT HEALTH HISTORY

Does the student have any serious disorder, such as asthma, ulcers, epilepsy? ☐ Yes ☐ No
If yes, please indicate:_____

Has the student had major surgery (hernia, appendectomy, etc.) within the past six months? ☐ Yes ☐ No
If yes, please indicate:_____

Is the student allergic to any drugs? ☐ Yes ☐ No
If yes, please indicate:_____

Is the student currently taking prescribed medicine of which the college should be aware? ☐ Yes ☐ No
If yes, please indicate:_____

Is the student undergoing treatment for any disorder? ☐ Yes ☐ No
If yes, will this treatment be continued while the student is in college? ☐ Yes ☐ No

Does the student have limitation on participation in physical education? ☐ Yes ☐ No
If yes, degree of limitation:_____

Does the student have any abnormalities which require special facilities and/or special consideration? ☐ Yes ☐ No

Has the student any history of mental or emotional disorders? ☐ Yes ☐ No

REQUIRED IMMUNIZATION

Measles, Mumps, Rubella (MMR)
Laramie County Community College requires each incoming student born on or after 1/1/57 to be protected against measles, mumps, and rubella. Compliance with the requirement is in one of three ways, as follows.

☐ Born PRIOR to January 1, 1957

☐ Have titers drawn. If immunity is not indicated by the titers, then you must either start the two-dose series or have a booster and another MMR titer drawn in six weeks. (attach copy of titers results)

☐ Recipt of 2 MMR vaccinations REQUIRES SIGNATURE OF MEDICAL PROVIDER (at bottom of this page)

MMR #1 _____ (date) Must be 12-15 months of age or later

MMR #2 _____ (date) Usually at age 4-6 year old or older, and at least one month after first dose

LCCC TB Screening

Tuberculosis evaluations are required prior to enrolling at LCCC if you:

☐ Were born or lived outside the United States

☐ Traveled outside the United States within twelve (12) months prior to arriving at LCCC.

If you checked either of the above boxes, you are required to obtain a two-step TB skin test and update it annually. Provide documentation of the PPD Mantoux Skin Test performed in the US prior to attendance within 48 hours of arrival on campus.

RECOMMENDED IMMUNIZATIONS

The following immunizations are recommended to lessen the risk of certain contagious diseases.

Hepatitis B Compliance with the requirement is in one of the following ways.

☐ Verify the three-dose series by receiving the first dose, then one month later receive the second does, and then five months later receive the last dose.

Dates: dose #1_____ dose #2_____ dose #3_____

☐ You may choose to have a titer drawn instead. If immunity is not indicated by the titer, then you must have a booster or start the three-dose series again depending on your health care provider's recommendation.

Date of _____ blood test showing immunity (Hep B SAb; attach copy of results)

Tetanus-Diphtheria (TD)

☐ Dates: Primary series with DTaP or DTP#1 _____ #2_____ #3_____ #4_____ #5_____

☐ Dates: Tetanus-diphtheria booster (circle Td or Tdap) within past 10 years. booster #1_____ booster #2_____

Varicella (Chicken Pox)

☐ Verify two doses of the varicella vaccine

Dates: dose #1_____ dose #2_____

☐ Have the titer drawn to verify immunity. Having had the chicken pox disease does not mean you have immunity.

Date: _____ History of disease (chickenpox)

Date: _____ Blood test showing immunity (attach copy of results)

Polio (primary series in childhood)

☐ OPV, four does Dates: dose #1_____ dose #2_____ dose #3_____ dose #4_____

☐ IPV, four does Dates: dose #1_____ dose #2_____ dose #3_____ dose #4_____

Human Papilloma Virus (three doses of the vaccine)

☐ Gardasil ☐ Cervarix Dates: dose #1_____ dose #2_____ dose #3_____

☐ **Influenza**

TO BE COMPLETED BY A PHYSICIAN

This student has been examined by me and found to be in good physical health: ☐ Yes ☐ No

Note any special health problems: _____

_____

_____

_____ _____

Signature of physician Date Signature of student Date

Emergency Treatment

Permission is given to any available physician or member of a hospital medical staff to perform emergency treatment

and procedures for _____ (student's name) as he/she deems necessary and to continue treatment and procedures until such time as the undersigned shall dismiss him/her or engage another physician. This permission includes admission to one of the local hospitals if the attending physician deems necessary.

_____ _____

Signature of student Date Signature of Parent/Guardian (if under 21) Date