



EDGEWOOD COLLEGE

Wellness Center

HEALTH SERVICES

INTERNATIONAL STUDENT HEALTH STATEMENT

CONFIDENTIALITY NOTICE

This information is strictly for the use of the Student Health Center and will not be released to anyone without your knowledge and written consent.

Last Name (Family name)		First Name (Given name)		Date of Birth	Student I.D. #
Home Country Address				Local Phone # ()	
City	Province	Country	Postal Code	Student Cell Phone # ()	
Emergency Contact (Name)		(Relationship)		(Phone #)	

PART 1. STUDENT VERIFICATION

By signing below, I am affirming that I have read the enclosed information regarding hepatitis B and meningitis. I am also certifying that the information on this form is complete and accurate to the best of my knowledge.

Student Signature

Date

PART 2. TUBERCULOSIS SCREENING (TO BE COMPLETED AFTER ARRIVAL ON CAMPUS)

TB screening must be completed within 2 weeks of the start of the semester. Please contact Edgewood College Health Services by email (healthservices@edgewood.edu) or phone (608) 663-8334.

	METHOD	RESULT	DATE
TB TEST RESULTS			

PART 3. HEALTH CARE PROVIDER VERIFICATION

Health Care Provider Signature

Date