

HEALTH STATEMENT FOR VISITING STUDENTS

COMPLETION OF THIS FORM IS REQUIRED FOR EVERY STUDENT PARTICIPATING IN A VISITING STUDENT ELECTIVE AT THIS SCHOOL. THE COMPLETED FORM MUST BE SUBMITTED WITH YOUR APPLICATION.

NAME: _____ ID#/SSN: _____

HOME SCHOOL: _____ DOB: ___/___/___

ELECTIVE SELECTED: _____ ELECTIVE DATES: ___/___/___ to ___/___/___

TO BE FILLED OUT BY A HEALTH PROVIDER:

1. Does this student have any acute or chronic health problems? If yes, please explain.

2. Date of last physical exam: ___/___/___
Results of the exam: _____

3. PROOF OF IMMUNITY:

	Vaccine		Titer
	1st Date	2nd Date	
Measles:	___/___/___	___/___/___	_____
Mumps:	___/___/___		_____
Rubella:	___/___/___		_____
Varicella:	___/___/___	___/___/___	_____
Hepatitis B:	___/___/___	___/___/___	3rd Date ___/___/___
Tuberculosis:	Results:	_____	

I verify that the information is true.

Name: _____

Signature: _____

Address: _____

Telephone: _____

Email Address: _____

Date: _____

RETURN THIS FORM WITH YOUR COMPLETED APPLICATION TO THE VISITING STUDENT COORDINATOR.