intercultural PROGRAMS Northwest College

Immunization, Health & Emergency Treatment Form

Student's Name: _____

Date of Birth: _____ Country of Origin: _____
month/day/year

Required Measles, Mumps, Rubella (MMR) Immunization

Proof of immunity to MMR is a requirement for registration for classes at Northwest College.

This requirement is fulfilled if you meet one of the following criteria:

- ☐ Provide a copy of your immunizations records in English **OR**
- ☐ Have your physician, health care provider, or authorized immunization official complete the following:

I certify that the student named above has fulfilled the MMR requirement based on (check all that apply):

- ☐ Receiving two doses of MMR (combined vaccine):
  - 1st dose: _____ 2nd dose: _____
    month/day/year month/day/year
- ☐ Receiving two doses of the measles (rubeola) vaccine and two doses of the mumps vaccine:
  - Measles vaccine 1st dose: _____ and 2nd dose: _____
  - Mumps vaccine 1st dose: _____ and 2nd dose: _____
    month/day/year month/day/year
- ☐ Immune titer (blood test) shows immunity to measles and mumps. ****Provide lab report in English.****
- ☐ History of measles (rubeloa) disease: (month/year) _____
- ☐ History of mumps disease: (month/year) _____

Physician's name (please print): _____

Physician's signature: _____

Phone Number: _____

Date: _____ Physician's or Clinic's Stamp:

Emergency Contact Information

Immediate family member to be notified in case of emergency: _____

Relationship to student: _____ Phone Number: _____

Address: _____

Does this person speak English? □ Yes □ No If no, what language does he/she speak? _____

In what city is the closest U.S. Embassy or U.S. Consulate? _____

If you have an agent or program coordinator, may we contact him/her in case of an emergency and provide information related to your health/medical situation to them? □ Yes □ No

Agent/Coordinator's Name: _____

Agent/Coordinator's Phone number: _____

Agent/Coordinator's Location (city and country): _____

Health Information and Permission for Emergency Treatment

□ Yes □ No Do you have any chronic or recurrent health problems such as asthma, ulcers, epilepsy, emotional disorders, etc.? If yes, please explain. _____
_____
_____

□ Yes □ No Do you routinely take any medications? If yes, please list. _____
_____
_____

□ Yes □ No Do you have any drug allergies? If yes, please list any drugs you are allergic to. _____
_____
_____

Permission is given to any available physician or licensed staff of the NWC Student Health Services or hospital to perform health and emergency treatment and procedures for (student's name)_____ as is deemed necessary and to continue treatment and procedures until such time as the undersigned shall dismiss the physician or engage another physician. Permission includes admission to a local hospital if the attending physician deems it necessary.

PERSONS UNDER 18 YEARS OF AGE MUST HAVE SIGNATURE OF PARENT OR LEGAL GUARDIAN.

Date _____ Signature of Student: _____

Date_____ Signature of Parent/Legal Guardian: _____

Please return the completed form to:
kara.ryf@nwc.edu
or
amanda.enriquez@nwc.edu