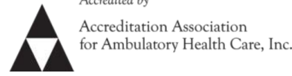
Health Services

For Health Center Only
Date/Initial:________________
Complete: yes no A
CCESS:_______
Hold:________ MCV4:_____TB:
MMR:____

Dr. Bob Smith Health Center
P.O. Box 750195, Dallas, Texas 75275-0195
Phone: 214-768-2141 Fax: 214-768-2151
Email: healthcenter@smu.edu Web: smu.edu/healthcenter



SMU STUDENT HEALTH FORM

Report of Health History, Consent of Medical Treatment, and Immunization Requirements for All Students

Name:___________________________/_____________________/_______ Gender: F M SMU ID#:_________________
Last First M.I.

Date of Birth: _____/_____/_____ Age:_______ Cell Phone:__________________ Email Address:__________________________
Month Day Year

Home Address:____City:________________State:___________ Zip:________

Semester Entering: Fall Spring Summer Year_________ Undergraduate Graduate International Student

Emergency Contact:
Name:____Relationship:________________Phone #:____________________

Medical History – Have you been treated for:

	YES			YES			YES	
ADD/ADHD			Eye Problems			**Allergy:**		**Type of Reaction**
Anemia			Head Injury (Concussions)			Codeine		
Anxiety/Panic Disorder			Heart Disease			Sulfa		
Arthritis			Hepatitis			Penicillin		
Asthma			High Blood Pressure			Insect bites/stings		
Bleeding Disorder			Kidney/Bladder/Urine Infections			Latex		
Cancer			Migraine Headaches			other		
Depression			Menstrual Disorder					
Diabetes			Mononucleosis					
Dizziness/Fainting			Orthopedic/Back/Bone Problems			**Surgery:**	Date:	
Ear, nose or throat disorder			Recent Weight Loss			Appendectomy		
Eating Disorder			Physical Limitations			Tonsillectomy		
Epilepsy/Seizures						Other		

Current Medications (including birth control and over the counter medications)______________________________________

____

Family History (parents, siblings, grandparents) for example – high blood pressure, cancer, diabetes, etc._________________

____

Consent to Medical Treatment: I authorize University Health Services and/or their consultants to administer medical and surgical services, required immunizations, TB testing, and to perform emergency procedures, as necessary, or refer to licensed personnel when indicated (including outside Hospitals).

____ ____
Signature Date Signature of Parent/Guardian (if student under 18) Date

Allow a minimum of seven (7) business days for delivery if mailed from a location within the United States and two (2) business days if faxed, emailed, or electronically submitted. Please submit at least two (2) weeks prior to your orientation/registration.

SMU is not responsible for forms not received due to mail that is misdirected or lost in transit. Incomplete or illegible submissions will not be processed.

Check **my.SMU** to verify completeness by going to: Health Center > Health History

IMMUNIZATION FORM

Name:____________________________ / ____________________________ /_____ Date of Birth:______/_______/_______

Last First MI Month Day Year

REQUIRED IMMUNIZATIONS FOR ALL STUDENTS (upload a legible copy of official immunization record)

1. Meningitis A Vaccine (Texas State law requires this for new students under age 22):

Menactra/Menveo/MCV4 ______/______/______

within past **5** years

2. **MMR (Measles, Mumps, Rubella)** (both doses must be after 1st birthday)

1st immunization ______/______/______

Date

2nd immunization _____/_____/_____

Date

VERIFICATION: ____________________________________ ___________________________ **OR** upload official immunization record

Doctor's Signature Office stamp

***If Doctor's signature is required, please download a copy of this form and fax or email after obtaining signature.**

RECOMMENDED BUT NOT REQUIRED:

1. Tetanus-Diphtheria

TD Booster/Tdap _____/_____/_____

(within past 10 years)

2. Hepatitis A: #1____/____/____ #2 ____/____/_____ Hepatitis B: #1____/____/____#2____/____/____ #3_____/_____/_____

Date Date Date Date Date

3. COVID-19 Vaccine: Have you received a COVID-19 vaccine?

If yes, which Type/Brand ________________ Date of Dose #1 _____/_____/_____ Date of Dose #2 _____/_____/_____

TB QUESTIONNAIRE: Country of Birth: ____________________________________

1. Were you born in any country OTHER than those listed below? YES NO
2. Have you arrived in the U.S. in the last 5 years? YES NO
3. Have you ever lived in any country OTHER than those listed below longer than 6 weeks and arrived in the U.S. in the last 5 years? YES NO
4. Do you have a history of IV drug abuse? YES NO
5. Do you have cancer, leukemia, kidney disease, diabetes, AIDS/HIV, or take immunosuppressive medications such as prednisone? YES NO
6. Have you been in close contact with someone sick with TB? YES NO
7. Have you resided, worked or volunteered in a prison, homeless shelter, hospital, nursing home or other long-term treatment facility? YES NO

Have you ever had a positive skin test in the past or been treated for TB? YES NO

If yes; please submit follow-up testing/chest x-ray and/or interferon gamma release assay (IGRA) results and dates. Please attach documentation to this form.

If you answered **"YES"** to any of the 7 questions above, you are required to have a IGRA (recommended) or a PPD skin test within the past 6 months.

You can obtain an IGRA or PPD skin test from your physician or public health clinic. Testing is also available at the SMU Student Health Center for a fee.

HEALTH CARE PROVIDER: Please record the size of the induration in millimeters. A result recorded as "Positive" or "Negative" will not be accepted. If there is no reaction please record "0 millimeters". If you have had a BCG vaccine you are still required to have a PPD skin test. If the TB skin test is abnormal, a chest x-ray is required and IGRA testing is strongly recommended. **Please attach all documentation or sign below**.

Date PPD Applied:_______________________ Date PPD Read:_______________________ Size of Induration___________________mm

Date of Chest X-ray:_________________________ Normal:______________Abnormal:______________

Date of IGRA testing, if done:_____________________Results:__________________

Health Care Provider's Signature: ____________________________________ Office Stamp:____

***If Doctor's signature is required, please download a copy of this form and fax or email after obtaining signature.**

Albania, Andorra, Antigua, Barbuda, Australia, Bahamas, Barbados, Belgium, British Virgin Islands, Canada, Chile, Costa Rica, Cuba, Cyprus, Czech Republic, Denmark, Egypt, Fiji, Finland, France, Germany, Greece, Grenada, Hungary, Iceland, Iran, Ireland, Israel, Italy, Jamaica, Jordan, Lebanon, Luxembourg, Malta, Mexico, Nauru, Netherlands, New Zealand, Norway, Oman, Puerto Rico, Saint Kitts, Nevis, Saint Lucia, Samoa, Saudi Arabia, Slovakia, Slovenia, Spain, Sweden, Switzerland, United Arab Emirates, United Kingdom, USA, West Bank and Gaza Strip.