SMU | Student Affairs — Health Services

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

Dr. Bob Smith Health Center
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Accredited by Accreditation Association for Ambulatory Health Care, Inc.

SMU STUDENT HEALTH FORM

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

*****Please Print Clearly******

Name:_____/_____/_____ Gender: F M SMU ID#:_____
Last First M.I. circle one

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
circle one circle one

Emergency Contact:
Name:_____Relationship:_____Phone #:_____

Medical History – Have you been treated for:

	YES	NO		YES	NO		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 or emailed. 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 **ACCESS.SMU** to verify completeness by going to: Student Self-Services>Student Center>Medical Health History

IMMUNIZATION FORM

Name:_____/_____/____ Date of Birth:_____/_____/_____
Last First MI Month Day Year

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

1. Meningitis Vaccine (Texas State law requires this for new students under age 22):
Menactra/Menveo/MCV4 _____/_____/_____
Circle One within past **5** years

2. **MMR (Measles, Mumps, Rubella)** (both doses must be after 1st birthday)
1st immunization _____/_____/_____
Date
2nd immunization _____/_____/_____
Date

VERIFICATION: _____ _____ **OR** attach official immunization record
Doctor's Signature Office stamp

RECOMMENDED BUT NOT REQUIRED:

1. Tetanus-Diphtheria
TD Booster/Tdap _____/_____/_____
Circle One (within past 10 years)

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

TB QUESTIONNAIRE: Country of Birth: _____ circle one

1. Were you born in any country OTHER than those listed below and arrived in the U.S. in the last 5 years?	Yes	No
2. 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
3. Do you have a history of IV drug abuse?	Yes	No
4. Do you have cancer, leukemia, kidney disease, diabetes, AIDS/HIV, or take immunosuppressive medications such as prednisone?	Yes	No
5. Have you been in close contact with someone sick with TB?	Yes	No
6. 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 6 questions above, you are required to have a PPD skin test within the past 6 months,
You can obtain the 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:_____

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.