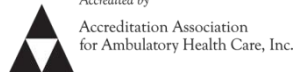




Dr. Bob Smith Health Center
P.O. Box 750195, Dallas, Texas 75275-0195
Phone: 214-768-2141 Fax: 214-768-2151
Email: healthcenter@smu.edu Web: smu.edu/healthcenter



For Health Center Only
Date/Initial:
Complete: yes no A
ACCESS:
Hold: MCV4: TB:
MMR:

SMU STUDENT HEALTH FORM

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

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

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

Table with 8 columns: Condition, YES, NO, Condition, YES, NO, Procedure, YES, Date. Rows include ADD/ADHD, Anemia, Anxiety/Panic Disorder, Arthritis, Asthma, Bleeding Disorder, Cancer, Depression, Diabetes, Dizziness/Fainting, Ear, nose or throat disorder, Eating Disorder, Epilepsy/Seizures, Eye Problems, Head Injury (Concussions), Heart Disease, Hepatitis, High Blood Pressure, Kidney/Bladder/Urine Infections, Migraine Headaches, Menstrual Disorder, Mononucleosis, Orthopedic/Back/Bone Problems, Recent Weight Loss, Physical Limitations, Allergy, Codeine, Sulfa, Penicillin, Insect bites/stings, Latex, other, Surgery, Appendectomy, Tonsillectomy, 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: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Last First MI

Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
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 1<sup>st</sup> birthday)

1<sup>st</sup> immunization \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

2<sup>nd</sup> 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.