SMU STUDENT HEALTH FORM
Report of Health History, Consent of Medical Treatment, and Immunization Requirements for All Students

Name: ____________________________ / ____________________________ / _______  Gender: F  M  SMU ID#: ________________

Date of Birth: ______ / ______ / ______  Age: ______  Cell Phone: __________________________  Email Address: __________________________

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:

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

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 M/ Month Day Year

REQUIRED IMMUNIZATIONS FOR ALL STUDENTS (upload a 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 _____/_____/____
   2nd immunization _____/_____/____

VERIFICATION:

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 _____/_____/____
   Circle One (within past 10 years)

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

3. COVID-19 Vaccine: Type/Brand __________________________
   #1_____/_____/____ #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.

HEALTH CARE PROVIDER’S SIGNATURE: __________________________ Office Stamp: __________________________

Date PPD Applied: ______________ Date PPD Read: ______________ Size of Induration ______________ mm

Date of Chest X-ray: __________________________ Normal: ______________ Abnormal: ______________

Date of IGRA testing, if done: __________________________ Results: __________________________

*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.