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. SMU ID#: __________________________

Gender: F M 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>
<thead>
<tr>
<th>ADD/ADHD</th>
<th>YES NO</th>
<th>Eye Problems</th>
<th>YES NO</th>
<th>Allergy:</th>
<th>YES Type of Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia</td>
<td></td>
<td>Head Injury (Concussions)</td>
<td></td>
<td>Codeine</td>
<td></td>
</tr>
<tr>
<td>Anxiety/Panic Disorder</td>
<td></td>
<td>Heart Disease</td>
<td></td>
<td>Sulfa</td>
<td></td>
</tr>
<tr>
<td>Arthritis</td>
<td></td>
<td>Hepatitis</td>
<td></td>
<td>Penicillin</td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td>High Blood Pressure</td>
<td></td>
<td>Insect bites/stings</td>
<td></td>
</tr>
<tr>
<td>Bleeding Disorder</td>
<td></td>
<td>Kidney/Bladder/Urinary Infections</td>
<td></td>
<td>Latex</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td>Migraine Headaches</td>
<td></td>
<td>other</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td>Menstrual Disorder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td>Mononucleosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<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>
</tr>
<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 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 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

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?

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.

TB QUESTIONNAIRE:

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.