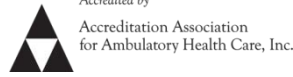




For Health Center Only
Date/Initial:
Complete: yes no A
ACCESS:
Hold: MCV4: TB:
MMR:

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

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 with 8 columns: Condition, YES, YES, Allergy/Surgery, Type of Reaction, 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.

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: _____/_____/_____
Last First MI

Date of Birth: ____/____/_____
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 ____/____/_____
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 ____/____/_____
Circle One (within past 10 years)

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

3. COVID-19 Vaccine: Type/Brand _____ #1 ____/____/_____ #2 ____/____/_____
Date Date

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.