ALL new students are **REQUIRED** to complete each page. Do not postpone your submission. **Registration will NOT be complete without all pages of this form.**

UNIVERSITY OF DALLAS

MEDICAL HISTORY FORM

Return to the Office of Student Life

(will be forwarded to University Health Center)

For the term beginning: __ Fall __Spring __Summer of 2______

STUDENT INFORMATION

To the student: This information will not affect your scholastic status. It will be used, if necessary, as an aid to provide health care while you are a student and as proof of immunization for the state of Texas. **This information is strictly for the use of the Student Health Services Center and will not be released to anyone without your knowledge and consent.**

Last name	First Name	Middle I.	Sex
Home Phone Number	Cell Number	Date of Birth	
Street Address		Apt. Number	
City	State	Zip Code	
SSN#	(If non-US citizen, please specify citizenship)		

FAMILY HISTORY

	Age	State of Health	Occupation	Age at Death	Cause of Death	List any relatives who have had:	
Father						Allergies/Hay Fever:	
Mother						Anxiety/Depression:	
Brothers						Asthma:	
						Cancer:	
						Diabetes:	
Sisters						Epilepsy:	
						High Blood Pressure:	
						High Cholesterol:	

PERSONAL HISTORY

Please check if you have had any of the following (include details and dates below).

Yes		Yes		Yes		Yes	
	Allergies to Medication		Heart Problems		Anxiety		Tumor, Cancer
			High Blood Pressure		Depression		Surgery:
	Chicken Pox		Rheumatic Fever		Dizziness/Fainting		Date?
	Mononucleosis				Headaches, Recurrent		
	Malaria		Stomach/Intestinal Problems		Weakness/Paralysis		Females only:
	Tuberculosis		Gallbladder Disease		Worry/Nervousness		Irregular Periods
			Gum/Tooth Trouble				Severe Cramps
	Allergy/Hay Fever		Weight Loss/Gain		ADD		Excessive Flow
	Asthma				Learning Difficulties		
	Ear, Nose, Throat Problems		Back Problems				Other:
	Eye Problems		Joint disease/Injury				

Have you ever had illness or injury or been hospitalized other than noted above?
___Yes ___No Give details →

Have you been treated by a psychiatrist, psychologist or other mental health practitioner? ___Yes ___No

Have you ever been hospitalized for any mental, emotional, or nervous disorder, or placed in a mental health facility?
___Yes ___No Give details →

Do you have any *serious* dietary problems?
___Yes ___No Give details →

____
Parent Signature (acknowledging review)

REMARKS OR ADDITIONAL INFORMATION

If you answered "YES" to any question on this page please explain below:
(Use additional sheet if necessary).

____

STUDENT SIGNATURE **Date**

University of Dallas - PHYSICIAN'S PHYSICAL REPORT

EXAMINING PHYSICIAN {may NOT be family member}: Please review the student's history and complete the Physician's Physical Report. Please comment on all positive answers. The information supplied will not affect the student's status. It will be used only as a background for providing health care, if necessary.
This information is strictly for the use of the University Clinic and will not be released without student consent.

Student's Last Name | First Name | M.I. | Sex

BP | Pulse | Height | Weight

R20/ L20/ | R20/ L20/ | Yes No
Uncorrected Vision | Corrected Vision | Contacts

Medications, including allergy injections:

Drug allergies:

Any significant past physical or emotional problems?

Please check the appropriate column:	*Normal*	*Abnormal*	**Comments**
Head, face, scalp			
Neck, thyroid, lymph nodes			
Eyes, ears, nose			
Mouth and throat			
Lungs and chest			
Breasts			
Heart			
Abdomen			
Back			
Genitalia (if indicated in females)			
Extremities and feet			
Neurological (reflexes, motor)			

RECOMMENDATION FOR PHYSICAL ACTIVITY (i.e., Intramurals, INTERCOLLEGIATE ATHLETICS)

___Unlimited ___Limited ___No Participation *Explain*:

Is this patient now under treatment for any medical or emotional condition?

___Yes ___No *Explain:*

Is there any reason why this student should **NOT** live in a University residence hall? Please explain:

Printed Physician's Name (may **NOT** be a family member) **PHYSICIAN'S SIGNATURE**

Address Telephone Number

City, State, Zip Code Date

The law requires that parental permission be obtained for treatment of illness or injury of students under 18 years of age. **So that no delay might occur in the event of an emergency, the adjoining release section should be signed.**

Parents or guardians will be notified immediately of any such occurrence.

PARENT / GUARDIAN MEDICAL RELEASE:
I give permission for diagnostic, therapeutic and/or operative procedures should an emergency arise. In such an instance the University of Dallas, through its physician or other medical authority, may act with my approval in treating my son/daughter/ward.

Signature Date

Relationship

Immunization Record

The following are REQUIRED by the state of Texas. A conscientious exemption form from the Texas Department of State Health Services MUST be used to request exemption.
Additional details available at: http://www.dshs.state.tx.us/immunize/docs/faq_exemption.pdf

Last Name ______________________________________ First Name________________________________ M.I.______
All information must be in English.

Date of Birth: __________/______/_____________ Social Security# _____________/______________/______________

M.R. (Measles, Mumps, Rubella) (Two doses required)

Dose 1 given at age 12-15 months or later. . . . .**#1**_________/________(Mo./Yr.)

Dose 2 given at age 4-6 years or later, and at least one month after first dose. . . . . . **#2** ________/________ (Mo./Yr.)

TETANUS-DIPHTHERIA-PERTUSSIS
(Primary series with DTaP or DTP and booster with Td or Tdap in the ***last ten years*** meets requirements. Refer to ACIP for details.)

A. Primary series of four doses with DTaP or DTP.

(Mo./Yr.) **#1**________/________ **#2**________/________ **#3**________/________ **#4**________/________

B. Date of last Tetanus booster ***WITHIN THE LAST TEN YEARS***. . ________/________ (Mo./Yr.) [***Circle one*** — Td **OR** Tdap]

POLIO
(Primary series in childhood meets requirement; three primary series schedules are acceptable.)

1. OPV alone (oral Sabin three doses): (Mo./Yr.) **#1**________/_______ **#2**_______/______ **#3**________/_______
2. IPV alone (injected Salk four doses): (Mo./Yr.) **#1**_______/______ **#2**______/______ **#3**_______/_______ **#4**______/______
3. IPV/OPV sequential: (Mo./Yr.) **IPV #1**_____/_____ **IPV #2**_____/_____ **OPV #3**______/_____**OPV #4**_______/_____

VARICELLA
(Either a history of chicken pox, a positive Varicella antibody, or two doses of vaccine given at least one month apart fulfills recommendations.)

1. History of disease Date ____________
2. Varicella antibody _______/_______ (Mo./Yr.) Reactive [ ] Non-reactive [ ]
3. Immunization **Dose #1**. . . . . **#1** _______/_______ (Mo./Yr.)
   Dose #2. . . . . **#2** _______/_______ (Mo./Yr.)

GARDASIL (Females Only—Recommended but **NOT** required))

Immunization (Mo./Yrs.) #1______/________ #2______/________ #3______/________

HEPATITIS A

1. History of disease _____Yes _____No
2. Immunization **Dose #1**_________/_______ **Dose #2**_________/_______

HEPATITIS B (Three doses of vaccine or a positive Hepatitis surface antibody fulfills recommendations.)

1. Immunization (Mo./Yr.) **Dose #1** _______/_______ **Dose #2**_______/_______ **Dose #3**_______/_______
2. Hepatitis B surface antibody (Mo./Yr.) _______/_______ Result: Reactive [ ] Non-reactive [ ]

MENINGOCOCCAL (***Required effective January 1, 2012*** by the state of Texas for **ALL** incoming students.)
See top block for state link to exemption information. Must be within LAST FIVE YEARS to meet requirements.
Meningococcal polysaccharide vaccine (MPSV4) **-OR-** Meningococcal conjugate vaccine (MCV4) _______/_______ (Mo./Yr.)

TUBERCULOSIS SCREENING (*if student at risk*; PPD required regardless of prior BCG inoculation.)

Result: Negative [ ] Positive [ ] mm induration (horizontal diameter) __________ _______/______ (Mo./Yr.)

If PPD is positive, chest X-ray required: Result: Normal [ ] Abnormal [ ] _______/_______ (Mo./Yr.)

To Be Completed By Health Care Provider

Print Name ____ Area Code + Telephone (__________) ____________________

Signature ____ Date ______________________________

Address____ City/State/Zip ____________________________

University of Dallas
STUDENT LIFE MEDICAL INFORMATION

Name: ____
Last **First** **Middle I.**

SS#: ______________________ Date of Birth ____/____/____

EMERGENCY INFORMATION ***In case of emergency, please contact:***

Family Member: ____
Relationship: ____

Home Phone: (______)__________ Cell Phone:(______)__________ Work Phone: (___)__________

INSURANCE (Be sure to bring your insurance card with you when you begin classes. Also, submission of this information does *NOT* constitute a waiver of the University health insurance.)

Subscriber ______________________ Subscriber SSN______________
Name of Insurance______________________ Subscriber D.O.B. __/____/____
Policy / ID# ______________________ Group #______________
Insurance company address ______________________________
Insurance phone number ______________________________

[Note: Full disclosure is important for proper care in case of emergency.
The Office of Student Life keeps all information confidential.]

Allergies (medicine, food, insects, etc.) ______________________________
____

Medications you currently take:

1. ______________________ For:______________________
   How long have you been on this medication? ______________________
2. ______________________ For: ______________________
   How long have you been on this medication? ______________________
3. ______________________ For: ______________________
   How long have you been on this medication? ______________________
4. ______________________ For: ______________________
   How long have you been on this medication? ______________________

Medical conditions (diabetes, heart, respiratory, depression, anxiety, etc.)

1. ____
2. ____
3. ____

STUDENT SIGNATURE: ______________________ **Date**: ______________

PARENT/GUARDIAN MEDICAL RELEASE (*Must be completed for students under 18 years of age*.)
I give permission for diagnostic, therapeutic, and/or operative procedures should an emergency arise. In such an instance, the University of Dallas, through its physician or other medical authority, may act with my approval in treating my son/daughter/ward.

Signature: ______________________________ **Date** ______________