

Report of Medical History and Consent of Medical Treatment

Name (Last, First, Middle)				Student Identification Number	
Home Address (Number and Street, City, State, Zip)				Area Code & Telephone No. (student)	
Date of Birth	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other	Citizenship	
Person to notify in case of illness, injury, or emergency: Name, Relationship, Street Address					
City, State, Zip		Home Telephone No.		Business Telephone No. or Cell No.	

*** Are you a non-traditional student (born after 1983 and not living in on-campus housing)? Yes No**
If yes, only TB and Tetanus are required. See below. *

Are you Active Military? Yes No If yes, proof of immunizations is not required.

PROOF OF THE FOLLOWING 4 IMMUNIZATIONS IS REQUIRED BY McM PRIOR TO REGISTRATION

*** TUBERCULOSIS** (A Negative Test OR Chest X-Ray within Past One Year)

TB SKIN TEST Date _____ Results _____

CHEST X-RAY Date _____ Results _____

Have you ever had BCG vaccine? If yes, date _____

HEPATITIS B Vaccine

DOSE #1 Date _____

DOSE #2 Date _____

DOSE #3 Date _____

*** TETANUS/DIPHTHERIA** Booster within 10 Years Date _____

MMR (Measles, Mumps, Rubella) Two injections since age two.

DOSE #1 Date _____

DOSE #2 Date _____

ALL STUDENTS BORN AFTER 1957 MUST PROVIDE PROOF OF IMMUNITY TO MEASLES, MUMPS, AND RUBELLA.

ACCEPTABLE PROOF IS CONSIDERED TO BE:

1. RECORD OF IMMUNIZATION SIGNED BY PERSONAL PHYSICIAN.
2. DOCUMENTATION OF DISEASE BY A PHYSICIAN.
3. PROTECTIVE TITER.

AUTHORIZED SIGNATURE:

PHYSICIAN, PUBLIC HEALTH CLINIC, OR TRANSCRIPT FROM SCHOOL RECORDS

Signature _____

Title _____

Address _____

City, State, Zip _____

Telephone No. _____ Fax No. _____

RECOMMENDED (But Not Required)

Hepatitis A Vaccine Meningococcal Vaccine

DOSE #1 Date _____ Date _____

DOSE #2 Date _____

Please List Allergies: _____ Drugs: _____

Consent to Medical Treatment

I authorize the Campus Nurse and/or consultants to administer medical services and immunizations, and to perform emergency and therapeutic procedures, as necessary, or refer to licensed medical personnel when indicated (including to nearby hospitals).

 Signature of Student if 18 years or over Date

 Signature of Parent or Guardian if Student is under 18 Date

PERSONAL HISTORY

Please answer all questions. Comment on all positive answers in space below.

Have you had or have you now?

	YES	YEAR	NO		YES	YEAR	NO		YES	YEAR	NO		YES	YEAR	NO
German Measles, Rubella				Head injury with unconsciousness				Rheumatic Fever or Heart Murmur				Albumin/Sugar in Urine, Diabetes			
Measles				Dizzy Spells, Fainting				Heart Disease				Kidney Disease			
Mumps				Weakness, Paralysis				High Blood Pressure				Frequent Urination			
Chicken Pox				Tuberculosis				Pain/Pressure in Chest				Inf. Mononucleosis			
Epilepsy, Convulsions				Asthma				Chronic Cough				Inf. Hepatitis			
Eye trouble				Shortness of Breath				Rupture, Hernia				Other Medical Condition Or Surgery List:			
Ear, Nose, Throat trouble				Disease/Injury of Joints, Back				Stomach/Intestine Trouble							
Insomnia				ALLERGY				Gall Bladder Trouble or Gallstones							
Frequent Anxiety				Penicillin											
Frequent Depression				Sulfonamides				Recurrent Diarrhea				FEMALES ONLY	YES	YEAR	NO
Worry or Nervousness				Serum				Recent Gain or Loss of weight				Irregular Periods			
Recurrent Headaches				Foods								Severe Cramps			
Recurrent Colds				Others: List								Excessive Flow			
Tumor, Cancer, Cyst												Pap Smear Date:			
Venereal Disease												Results:			

Comments/Medications:

FAMILY HISTORY

	AGE	OCCUPATION	AGE @ DEATH	CAUSE OF DEATH	List details below to YES responses	YES	NO
Father					A. Has your physical activity been restricted during the past five years?		
Mother					B. Have you ever received treatment or counseling for a nervous condition, personality, or character disorder, or emotional problem?		
Brothers							
					C. Do you take any prescription medications?		
Sisters							
					Comments:		
Student Signature. I certify all questions are answered accurately.							

Students may need to be referred off campus for more extensive medical care. Medical insurance is required. Please supply copy of front and back of insurance card.

Name of Insurance Company _____

Address, City, State, Zip _____

Telephone No. _____

Subscriber's Name _____ SS# _____

Employer _____ Group ID# _____

I understand that health insurance is **required** to attend McMurry University. McMurry is not responsible for any expenses that may result from injury or illness that occur on or off campus. A copy of the front and back or your insurance card must be kept on file in the Health Services office.

Signature _____ Date _____

By signing below, I acknowledge that I have received written information about Bacterial Meningitis with this form.

Signature _____ Date _____