

McMurry University International

Complete and Mail to:
Campus Nurse
1 McMurry University # 716
Abilene TX 79697 - 0716
 Phone: 325 - 793 - 4857
 Fax: 325 - 793 - 4879

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.	

PROOF OF THE FOLLOWING 4 IMMUNIZATIONS IS REQUIRED BY McM PRIOR TO REGISTRATION
May send copy of official immunization record.

*** BACTERIAL MENINGITIS Vaccine**

Must submit evidence of the vaccination. Acceptable evidence includes the following:

- The signature or stamp of a physician or his/her designee, or public health personnel, on a form which shows the month, day, and year the vaccination dose or booster was administered.
- An official immunization record generated from a state or local authority.
- An official record received from school officials, including a record from another state.

Available exemptions;

- Is 22 years of age or older on or before the first day of the term enrollment.
- Signs an affidavit declining the vaccination. Request must be made through the Department of State Health Services.

BACTERIAL MENINGITIS VACCINE - DATE _____

*** 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 one.

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

DOSE #1 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				Recurrent Diarrhea				FEMALES ONLY	YES	YEAR	NO
Frequent Depression				Sulfonamides				Recent Gain or Loss of weight				Irregular Periods			
Worry or Nervousness				Serum								Severe Cramps			
Recurrent Headaches				Foods								Excessive Flow			
Recurrent Colds				Others: List								Pap Smear Date:			
Tumor, Cancer, Cyst												Results:			
Venereal Disease															

Comments/Medications:

FAMILY HISTORY

	If Living AGE	OCCUPATION	or 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							
Sisters					C. Do you take any prescription medications?		
					Comments:		
Student Signature. I certify all questions are answered accurately.							

I understand that international students attending McMurry University will be signed up for student health insurance and the charges will be charged to the student's account.

Signature _____ Date _____

Please sign below that you received written information about Bacterial Meningitis with this form:

Signature _____ Date _____