McMURRY UNIVERSITY

International

Complete and Mail to:
Campus Nurse
McMurry Station Box 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 ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ 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 IMMUNIZATIONS IS REQUIRED BY McM PRIOR TO REGISTRATION
Please have immunizations documented below.

* **BACTERIAL MENINGITIS (ACWY) Vaccine**

Must submit evidence of the vaccination or booster within 5 years of first date of class for semester starting. 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 (ACWY) VACCINE - DATE_____

* **TUBERCULOSIS** (See Tuberculosis Screening Questionnaire). If any questions answered yes, then a negative test OR chest x-ray is required **within Past One Year**

TB SKIN TEST Date _____ Results _____

CHEST X-RAY Date _____ Results _____

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

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

Polio Vaccine – Four doses since age 2 months

DOSE #1 **Date** _____

DOSE #2 **Date** _____

DOSE #3 **Date** _____

DOSE #4 **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 _____

Hepatitis B Vaccine

DOSE #1 Date _____

DOSE #2 Date _____

DOSE #3 Date _____

Please List Allergies: _____

Drugs: _____

Consent to Medical Treatment

I authorize the University Nurse, University Nurse Practitioner and/or consultants to administer medical services and immunizations, and to perform emergency and therapeutic procedures, as necessary. I understand that depending on the nature of my illness and/or injury, I may be asked to remove articles of clothing. I understand that this is voluntary and if I am not comfortable I will say so immediately. I may be referred off campus to other licensed medical personnel (including nearby hospitals and/or walk-in clinics) if a thorough assessment is unable to be performed or treatment exceeds the scope of practice of the providers in the clinic.

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
Father				
Mother				
Brothers				
Sisters				

List details below to YES responses	YES	NO
A. Has your physical activity been restricted during the past five years?		
B. Have you ever received treatment or counseling for a nervous condition, personality, or character disorder, or emotional problem?		
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 required to show proof of health insurance. If the student does not have health insurance or the policy does not meet the waiver requirements, the student will automatically be enrolled in a policy through the University and the charges for the premiums 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_____