McMURRY UNIVERSITY

PHSSN HEALTH FORM

This form MUST be completed before enrollment is finalized!

To the examining health care provider

Please review the student's past medical history on this form and complete the information below. Please comment *on* all positive responses. **The reverse side of this form is to be completed by the student but MUST also be signed by the health care provider. According to Texas State Law, evidence of a current TB and immunization MUST be provided.**

Student's First Name: _____ Last: _____
Middle:_____ Date of Birth:_____ SS#_____ Sex: _____ Citizenship: _____

IMMUNIZATION REQUIRED

IMMUNIZATION REQUIRED	Date of FIRST Injection: (month-date-year)	Date of SECOND Injection: (month-date-year)	Titer (positive/ negative)
RUBELLA			
MEASLES-RUBEOLA			
MUMPS			
CHICKEN POX			

	1ST SHOT	2ND SHOT	3RD SHOT	TITER (POS/NEG)
HEPATITIS B SERIES				

	SERIES COMPLETE	DATE OF LAST INJECTION
POLIO		
TETANUS/DIPTHERIA/ PERTUSSIS		

**It is highly recommended that if you have not had Chicken Pox, that you get the Chicken Pox vaccine.*

TUBERCULIN SKIN TEST: Positive _____ Negative _____ Date:_____
If TB test positive, chest x-ray date: _____ Results:_____
_(must be current with past 12 months)
___Medication:_____

Blood Pressure:
Corrected Vision: Right 20/_ . Left 20/_ Height:_ . Weight:_

Are there any abnormalities of the following systems? If so, attach a description on separate page.

_YES __ NO Head, ears, nose or throat
_YES __ NO Respiratory
_YES __ NO Cardiovascular
_YES __ NO Gastrointestinal
_YES __ NO Hernia
_YES ____NO Eyes
_YES ____NO Genitourinary
_YES ____NO Musculoskeletal
_YES ____NO Metabolic/Endocrine
_YES ____NO Neuropsychiatry
_YES ____NO Skin
_YES ____NO Loss or impaired function of any organ
_YES ____NO Limited physical activity
_YES ____NO Is the student now under treatment for any medical or emotional condition? (if yes, describe)
_YES ____NO Any general comments or recommendations regarding the care of this student? (if yes, describe)

SEE REVERSE SIDE OF THIS FORM!

TO BE COMPLETED BY STUDENT

Past Medical History:

Have you had any of the following? Please answer each, commenting on all positive replies below. Use additional paper if necessary.

_Yes _No Scarlet Fever	_Yes _No Recurrent Colds	_Yes _ No Stomach or Intestinal problems
_Yes _No Measles	_Yes _No Head injury w/unconsciousness	_Yes _ No Tumor, cancer, cyst
_Yes _No German measles	_Yes _No Hay fever, asthma	_Yes _No Jaundice
_Yes _No Mumps	_Yes _No Tuberculosis	_Yes _No Gallbladder problems
_Yes _No Chicken Pox	_Yes _No Shortness of breath	_Yes _ No Diabetes
_Yes _No Malaria	_Yes _ No Pain/pressure in chest	_Yes _No Recent weight loss
_Yes _No Dental problems	_Yes _ No Heart palpitation	_Yes _No Recent weight gain
_Yes _No Sinusitis	_Yes _ No Chronic cough	_Yes _No Epilepsy
_Yes _No Eye trouble	_Yes _ No High/low blood pressure	_Yes _No Dizziness, fainting
_Yes _No Ear, Nose	_Yes _ No Rheumatic fever or heart murmur	_Yes _No Weakness, paralysis
_Yes _No Insomnia	_Yes _ No Disease or injury to joints	_Yes _No Albumin/sugar in urine
_Yes _No Frequent anxiety	_Yes _ No Knee/shoulder pain	_Yes _No Frequent urination
Yes No Recurrent headache	_Yes _ No Menstrual problems	_Yes _No Seizures

Comments: _____

_____

_____

_____

_____

_____

_____

Please list any prescriptive medication or over the counter medication that you take on a regular basis: _____

_____

Please list all surgeries: _____

_____

Please list any allergies

_Yes _No Medications_____

_Yes _No Foods _____

_Yes _No Environment_____

_Yes _No Has your physical activity been restricted during the past five years? Give reason and duration.

_Yes _No Have you been diagnosed with Attention Deficit Disorder or ANY learning disability?

_Yes _No Have you received treatment or counseling for a nervous condition or emotional problem? Give details.

_Yes _No Have you had any illness or injury or been hospitalized for reasons other than already noted? Give details.

_Yes _No Have you visited physicians or other professionals in the past five years for other than routine checkups?

_____ _____

Health Care Provider's Signature (acknowledging review) **Date**

_____ _____

Student's signature **Date**