McMurry University

Domestic Students

Report of Medical History and Consent of Medical Treatment

Return completed form to Health Services

Campus Nurse | 1 McMurry University #716 | Abilene, TX 79697-0001

Phone: 325-793-4857 Fax: 325-793-4879

Before registration

Submit required immunization documentation, this completed form, and a copy of the front and back of your insurance card.

Student Information

Name (Last, First, Middle) _____ Student ID _____

Home Address _____ Phone _____

Date of Birth _____ Age _____ Sex ☐ Male ☐ Female Citizenship _____

Marital Status ☐ Single ☐ Married ☐ Other _____

Emergency Contact

Name / Relationship _____

Street Address _____ City, State, Zip _____

Home Phone _____ Business / Cell Phone _____

Consent to Medical Treatment

If signed by a parent or guardian, authorization is only good until the student reaches their 18th birthday.

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

Student Signature (if 18 years or older) _____ Date _____

Parent/Guardian Signature (if student is under 18) _____ Date _____

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Required Immunization Documentation

Proof of the following immunizations is required by McMurry prior to registration.

You may submit a copy of an official immunization record. Complete this section and attach supporting records as needed.

Bacterial Meningitis Vaccine

Students must submit evidence of bacterial meningitis vaccination, booster, or exemption prior to registration. Acceptable evidence includes:

- ☐ Signature or stamp of a physician, designee, or public health personnel on a form showing the month, day, and year the dose or booster was administered.
- ☐ Official immunization record generated from a state or local health authority.
- ☐ Official record received from school officials, including a record from another state.

Available exemptions:

- ☐ Age 22 or older on or before the first day of the term of enrollment.
- ☐ Signs an affidavit declining the vaccination. Request must be made through the Department of State Health Services.
- ☐ Presents a physician certificate indicating the vaccination would injure the health of the student.

MMR - Measles, Mumps, and Rubella

Two injections since age one are required for all students. Acceptable proof is considered to be:

- ☐ Official immunization record generated from a state or local health authority or school.
- ☐ Record of immunization signed by a personal physician.
- ☐ Documentation of disease by a physician.
- ☐ Document indicating protective titer.

Available exemption:

- ☐ Presents a physician certificate indicating the vaccination would injure the health of the student.

Tuberculosis

Complete the Tuberculosis Screening Questionnaire. If any questions are answered yes, a negative test or chest X-ray is required within the past one year.

- ☐ Tuberculosis Screening Questionnaire attached
- ☐ Negative test or chest X-ray attached, if required

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Personal History

Please answer all questions. Comment on all YES answers.

Check YES or NO for each item. Add the year when applicable. Use the comments box for details about any YES answers, current medications, allergies, or other medical conditions.

Condition	Yes	Year	No
German Measles / Rubella	☐		☐
Measles	☐		☐
Mumps	☐		☐
Chicken Pox	☐		☐
Epilepsy / Convulsions	☐		☐
Eye trouble	☐		☐
Ear, Nose, Throat trouble	☐		☐
Insomnia	☐		☐
Frequent Anxiety	☐		☐
Frequent Depression	☐		☐
Worry or Nervousness	☐		☐
Recurrent Headaches	☐		☐
Recurrent Colds	☐		☐
Tumor, Cancer, Cyst	☐		☐
Venereal Disease	☐		☐
Head injury with unconsciousness	☐		☐
Dizzy Spells / Fainting	☐		☐
Weakness / Paralysis	☐		☐
Tuberculosis	☐		☐
Asthma	☐		☐
Shortness of Breath	☐		☐
Disease / Injury of Joints, Back	☐		☐

Condition	Yes	Year	No
Allergy - Penicillin	☐		☐
Allergy - Sulfonamides	☐		☐
Allergy - Serum	☐		☐
Allergy - Foods	☐		☐
Allergy - Other	☐		☐
Rheumatic Fever / Heart Murmur	☐		☐
Heart Disease	☐		☐
High Blood Pressure	☐		☐
Pain / Pressure in Chest	☐		☐
Chronic Cough	☐		☐
Rupture / Hernia	☐		☐
Stomach / Intestine Trouble	☐		☐
Gall Bladder Trouble or Gallstones	☐		☐
Recurrent Diarrhea	☐		☐
Recent Gain or Loss of Weight	☐		☐
Albumin / Sugar in Urine, Diabetes	☐		☐
Kidney Disease	☐		☐
Frequent Urination	☐		☐
Infectious Mononucleosis	☐		☐
Infectious Hepatitis	☐		☐
Other Medical Condition or Surgery	☐		☐

Females Only ☐ Irregular periods ☐ Severe cramps ☐ Excessive flow

Pap Smear Date _____ Results _____

Comments / Medications

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Family History and Student Certification

Family History

Complete the family history section below. Use the details area to explain any YES responses.

Family Member	Age	Occupation	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Additional Questions

A. Has your physical activity been restricted during the past five years? **Yes** ☐ **No** ☐

B. Have you ever received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem? **Yes** ☐ **No** ☐

C. Do you take any prescription medications? **Yes** ☐ **No** ☐

Details / Comments

Student Certification

I certify all questions are answered accurately.

Student Signature _____ Date _____

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Acknowledgements and Submission Checklist

Health Insurance Acknowledgement

☐ I understand that health insurance is required to attend McMurry University. McMurry is not responsible for any expenses that incur from injury or illness that occur on or off campus. I will supply a copy of the front and back of my insurance card.

Signature _____ Date _____

Bacterial Meningitis Information Acknowledgement

☐ I received written information about Bacterial Meningitis with this form.

Signature _____ Date _____

Submission Checklist

- ☐ Completed medical health form signed and dated
- ☐ Official immunization records attached
- ☐ Tuberculosis Screening Questionnaire and additional test results attached, if required
- ☐ Copy of front and back of health insurance card attached

Notice of Privacy Practices and PHI Authorization

I acknowledge that I have received the Notice of Privacy Practices and authorize McMurry University to discuss my protected health information (PHI) with the individuals listed below.

Authorized Individual 1

Name _____ Relationship _____ Phone _____

Authorized Individual 2

Name _____ Relationship _____ Phone _____

Signature of Student or Legal Representative _____ Date _____

Printed Name _____ Relationship to Student _____