

Before you begin: Complete all sections, attach official immunization records, and provide a copy of the front and back of your health insurance card. Incomplete forms may delay registration or clearance.

1. Student Information

Name (Last, First, Middle)

Student ID Number

Home Address (Street, City, State/Province, Postal Code, Country)

Student Phone Number

Date of Birth

Age

Citizenship

Student Email

Sex

Male

Female

Marital Status

Single

Married

Other

2. Emergency Contact

Person to notify in case of illness, injury, or emergency

Relationship

City, State/Province, Postal Code, Country

Phone Number

3. Required Documentation Summary

- **Bacterial Meningitis Vaccine:** Required prior to registration; include dose or booster date and official documentation.
- **Tuberculosis Screening:** If any screening question is answered yes, provide a negative test or chest x-ray within the past year.
- **Hepatitis B Vaccine:** Three-dose series documentation is required.
- **Tetanus/Diphtheria Booster:** Booster within the past 10 years is required.
- **MMR:** Two injections since age one; students born after 1957 must provide proof of immunity to measles, mumps, and rubella.

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Required Immunizations

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

Attach a copy of the official immunization record. Acceptable proof may include an official immunization record, a record signed by a physician or public health clinic, a transcript from school records, documentation of disease by a physician, or a protective titer where applicable.

Bacterial Meningitis Vaccine

Bacterial Meningitis Vaccine Date

Documentation Attached?

Yes

Acceptable evidence includes: a physician or designee signature or stamp showing the month, day, and year the dose or booster was administered; an official immunization record generated by a state or local health authority; or an official record from school officials. **Exemptions:** age 22 or older by the first day of the term, DSHS affidavit declining vaccination, or a physician certificate indicating vaccination would injure the student's health.

Tuberculosis Screening

TB Skin Test Date

Results

Chest X-Ray Date

Chest X-Ray Results

Have you ever had BCG vaccine?

Yes

No

If yes, date

Hepatitis B Vaccine

Dose #1 Date

Dose #2 Date

Dose #3 Date

Tetanus/Diphtheria Booster

Booster date - within 10 years

MMR - Measles, Mumps, Rubella

Dose #1 Date

Dose #2 Date

All students born after 1957 must provide proof of immunity to measles, mumps, and rubella. Acceptable proof includes physician-signed immunization record, physician documentation of disease, or protective titer.

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Provider Authorization, Consent, and Acknowledgements

Recommended Vaccination, Allergies, and Provider Authorization

Hepatitis A Dose #1 Date

Dose #2 Date

Please list allergies - drugs

Other allergies

Authorized signature

Title

Phone

Address

Fax

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 referral to nearby hospitals.

Signature of Student if 18 years or over

Date

Signature of Parent or Guardian if Student is under 18

Date

International Student Health Insurance Acknowledgement

I understand that international students attending McMurry University will be required to show proof of health insurance or the student will be required to purchase insurance through the university, and the charges will be applied to the student's account.

Signature

Date

Bacterial Meningitis Information Acknowledgement

Please sign below to acknowledge that you received written information about Bacterial Meningitis.

Signature

Date

Please answer all questions. Check Yes or No for each item. If Yes, include the year when possible and explain positive answers in the Comments/Medications area.

German Measles, Rubella	<input type="checkbox"/> Yes	<input type="text"/>	<input type="checkbox"/> No
Mumps	<input type="checkbox"/> Yes	<input type="text"/>	<input type="checkbox"/> No
Epilepsy, Convulsions	<input type="checkbox"/> Yes	<input type="text"/>	<input type="checkbox"/> No
Ear, Nose, Throat trouble	<input type="checkbox"/> Yes	<input type="text"/>	<input type="checkbox"/> No
Frequent Anxiety	<input type="checkbox"/> Yes	<input type="text"/>	<input type="checkbox"/> No
Worry or Nervousness	<input type="checkbox"/> Yes	<input type="text"/>	<input type="checkbox"/> No
Recurrent Colds	<input type="checkbox"/> Yes	<input type="text"/>	<input type="checkbox"/> No
Venereal Disease	<input type="checkbox"/> Yes	<input type="text"/>	<input type="checkbox"/> No
Dizzy Spells, Fainting	<input type="checkbox"/> Yes	<input type="text"/>	<input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes	<input type="text"/>	<input type="checkbox"/> No
Shortness of Breath	<input type="checkbox"/> Yes	<input type="text"/>	<input type="checkbox"/> No
Allergy	<input type="checkbox"/> Yes	<input type="text"/>	<input type="checkbox"/> No
Sulfonamides	<input type="checkbox"/> Yes	<input type="text"/>	<input type="checkbox"/> No
Foods	<input type="checkbox"/> Yes	<input type="text"/>	<input type="checkbox"/> No

Measles	<input type="checkbox"/> Yes	<input type="text"/>	<input type="checkbox"/> No
Chicken Pox	<input type="checkbox"/> Yes	<input type="text"/>	<input type="checkbox"/> No
Eye trouble	<input type="checkbox"/> Yes	<input type="text"/>	<input type="checkbox"/> No
Insomnia	<input type="checkbox"/> Yes	<input type="text"/>	<input type="checkbox"/> No
Frequent Depression	<input type="checkbox"/> Yes	<input type="text"/>	<input type="checkbox"/> No
Recurrent Headaches	<input type="checkbox"/> Yes	<input type="text"/>	<input type="checkbox"/> No
Tumor, Cancer, Cyst	<input type="checkbox"/> Yes	<input type="text"/>	<input type="checkbox"/> No
Head injury with unconsciousness	<input type="checkbox"/> Yes	<input type="text"/>	<input type="checkbox"/> No
Weakness, Paralysis	<input type="checkbox"/> Yes	<input type="text"/>	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="text"/>	<input type="checkbox"/> No
Disease/Injury of Joints, Back	<input type="checkbox"/> Yes	<input type="text"/>	<input type="checkbox"/> No
Penicillin	<input type="checkbox"/> Yes	<input type="text"/>	<input type="checkbox"/> No
Serum	<input type="checkbox"/> Yes	<input type="text"/>	<input type="checkbox"/> No
Other allergies - list	<input type="checkbox"/> Yes	<input type="text"/>	<input type="checkbox"/> No

Comments / Medications

Rheumatic Fever or Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/> No	Pain/Pressure in Chest	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/> No
Chronic Cough	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/> No	Rupture, Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/> No
Stomach/Intestine Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/> No	Gall Bladder Trouble or Gallstones	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/> No
Recurrent Diarrhea	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/> No	Recent Gain or Loss of Weight	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/> No
Albumin/Sugar in Urine, Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/> No
Frequent Urination	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/> No	Infectious Mononucleosis	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/> No
Infectious Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/> No	Other Medical Condition or Surgery - list	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/> No
Irregular Periods	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/> No	Severe Cramps	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/> No
Excessive Flow	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/> No				

Females only - Pap Smear Date

Results

Additional Comments / Medications

Student Signature - I certify all questions are answered accurately.

Date

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Family History and Final Submission

Family History

Family Member	Age	Occupation	Age at Death	Cause of Death
Father	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Mother	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Brothers	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Sisters	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Additional Health Questions

- Has your physical activity been restricted during the past five years? Yes No
- Have you ever received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem? Yes No
- Do you take any prescription medications? Yes No

Comments

Submission Checklist

- Completed student information and emergency contact sections
- Official immunization record attached
- Tuberculosis screening documentation attached, if required
- Health insurance card copy attached - front and back
- Consent and acknowledgement signatures completed

Final Reminder

Submit the completed form with official immunization records and a copy of the front and back of your health insurance card. Keep a copy for your records.

McMurry University Health Services

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