

UNIVERSITY OF DALLAS

Student Health Services Center

Welcome to University of Dallas! The following Health Form is both required and time-sensitive. Failure to complete the required information will impact your ability to attend class and move into your residence hall.

The Health Form must be returned by July 1, 2019. For students confirming after July 1, Health Forms will be processed on a rolling basis as they are completed and submitted. We highly recommend that you keep a copy for your records.

- Personal & Family History page
- Physical Exam page
- Immunization Record
- Emergency Information - Including a copy of the front and back of your current insurance card.

TAKE ALL 4 PAGES to your appointment for your physical exam.

PERSONAL AND FAMILY HISTORY - Page 1 of 4

Personal and Family History: Please complete all sections. This page must be **signed** by both a parent/legal guardian and the student and reviewed by your provider at your physical exam.

PHYSICAL EXAMINATION - Page 2 of 4

Physical Exam: A licensed Physician, Nurse Practitioner or Physician's Assistant **must complete and sign** the Physical Exam page and review the other 3 pages of the Health Form. The examining physician may **NOT** be a family member.

IMMUNIZATION RECORD - Page 3 of 4

Immunization Record: Please fill out both the 'Required' and 'Recommended' sections **completely** and have the page **signed by a medical provider**. Option - A copy of other school records of your immunizations will suffice, *providing* it meets all of our requirements and your doctor signs the Immunization page as confirmation of your records. Failure to complete immunizations will impact your ability to register for classes and move on campus.

EMERGENCY INFORMATION AND AUTHORIZATION SIGNATURE - Page 4 of 4

Emergency Information: All areas must be completed. If the student is less than 18 years of age, the page must be signed by a parent/legal guardian. If the student is covered under an insurance plan, please include a photo copy (front and back) of your insurance card with this page.

Form Return Methods

- Mail:** University of Dallas
Student Health Services Center
1845 E. Northgate Drive
Irving, Texas 75062
- Email:** Scan to PDF and email to udhealthclinic@udallas.edu
- Fax:** 972-721-5124

Medical Insurance Waiver – for your information

All new incoming full-time undergraduates (except domestic seminarians) are automatically enrolled in and charged for the student insurance program. However, the university health insurance coverage may be waived upon proper submission of an online waiver directly with the insurance company broker. September 16, 2019 is the deadline date for online waiver submissions. This is a process that must be completed each academic year.

The online waiver form will be available about May 1, 2019. An email will also be sent to your UD email address once the waiver page is activated and will include instructions on how to submit the online waiver.

ALL new students are **REQUIRED** to complete each page. Do not postpone your submission. **Registration will NOT be complete without all pages of this form.**

For the term beginning:

Fall of 20____ Spring of 20____

STUDENT INFORMATION

To the student: This information will not affect your scholastic status. It will be used, if necessary, as an aid to provide health care while you are a student and as proof of immunization for the state of Texas. **This information is strictly for the use of the Student Health Services Center and will not be released to anyone without your knowledge and consent.**

Last Name	First Name	Sex	Date of Birth
Email Address		Cell Number	Home Number
Street Address			Apt. Number
City	State	Zip Code	
UD Student ID#		(If non-US citizen, please specify citizenship)	

FAMILY HISTORY

	Age	State of Health	Occupation	Age at Death	Cause of Death	List any relatives who have had:
Father						Allergies/Hay Fever:
Mother						Anxiety/Depression:
Brothers						Asthma:
						Cancer (type):
Sisters						Diabetes:
						Epilepsy:
						High Blood Pressure:
						High Cholesterol:

PERSONAL HISTORY

Please check if you have had any of the following (include details and dates below).

Yes		Yes		Yes		Yes	
	Allergies to Medication		Heart Problems		Anxiety		Tumor, Cancer
			High Blood Pressure		Depression		Surgery:
	Chicken Pox		Sickle Cell Disease/Trait		Dizziness/Fainting		Date?
	Mononucleosis				Headaches, Recurrent		
	Malaria		Stomach/Intestinal Problems		Weakness/Paralysis		Females only:
	Tuberculosis		Gallbladder Disease		Worry/Nervousness		Irregular Periods
			Gum/Tooth Trouble				Severe Cramps
	Allergy/Hay Fever		Weight Loss/Gain		ADD/ADHD		Excessive Flow
	Asthma				Learning Difficulties		
	Ear, Nose, Throat Problems		Back Problems				Other:
	Eye Problems		Joint disease/Injury				

Have you ever had illness or injury other than noted above?
 Yes No Give details →

Have you been treated by a psychiatrist, psychologist or other mental health practitioner?
 Yes No

Have you ever been hospitalized for any physical or emotional disorder?
 Yes No Give details →

Do you have any *serious* dietary problems?
 Yes No Give details →

REMARKS OR ADDITIONAL INFORMATION

If you answered "YES" to any question on this page please explain below: (Use additional sheet if necessary).

PARENT Signature (acknowledging review if student under 25) **Date**

STUDENT Signature (required) **Date**

Physical Exam

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EXAMINING PROVIDER {may NOT be a family member}:

Please review the student's history (pg1), immunizations (pg 3), and medications (pg 4) and complete the Physical Exam signing at the bottom. Please comment on all positive answers. The information supplied will not affect the student's status. It will be used only as a background for providing health care.

This information is strictly for the use of the Student Health Services Center and will not be released without student consent.

Student's Last Name _____ First Name _____ M.I. _____ Sex _____

BP _____ Pulse _____ Height _____ Weight _____
 R20/ L20/ [] Yes [] No
 Uncorrected Vision Corrected Vision Contacts

Medications, including allergy injections: (review page 4)

Drug/Latex allergies:

Current medical or emotional condition? (review pages 1&4)

Significant past physical or emotional problems? (review page 1)

Please check the appropriate column:	Normal	Abnormal	Comments
Head, face, scalp			
Neck, thyroid, lymph nodes			
Eyes, ears, nose			
Mouth and throat			
Lungs and chest			
Breasts			
Heart			
Abdomen			
Back			
Extremities and feet			
Neurological (reflexes, motor)			

RECOMMENDATION FOR PHYSICAL ACTIVITY (i.e., Intramurals, INTERCOLLEGIATE ATHLETICS)
 Unlimited Limited No Participation
 Explain: _____
 History of Sickle Cell Trait or Disease? Yes No

Is there any reason why this student should NOT live in a University residence hall? [] No [] Yes
 Please explain:

Printed Physician's Name (may NOT be a family member) _____ **PHYSICIAN'S SIGNATURE** _____ Date _____
 Address _____ Telephone Number _____
 City _____ State _____ Zip Code _____

Immunization Record

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These guidelines follow those outlined by the American College Health Association (ACHA) for "Institutional Prematriculation Immunizations" and the Texas Department of State Health Services. Immunizations should be completed **PRIOR** to registration. Please fill out the form **COMPLETELY**.

Students seeking an **exemption** for those vaccines **REQUIRED** by the state of Texas must submit an exemption form from the Texas Department of State Health Services to the University of Dallas. A secure online request form for an exemption affidavit from the State of Texas is available at <https://corequest.dshs.texas.gov/>

Last Name _____ First Name _____ MI _____ DOB _____

REQUIRED Vaccines		Enter complete date (mo/day/yr)				
Hepatitis B	Hep B or Hep A/B	1.	2.	3.	or date of titer:	
					or date of disease:	
Meningococcal (if < 22 yrs old)	MCV-4 (A,C,W,Y)	1.	2.	(last dose within 5 yrs)		
Tetanus-Diphtheria-Pertussis	DTaP/DTP	1.	2.	3.	4.	5.
Tetanus booster	Td/Tdap (circle)	1.	(within 10 years)			

RECOMMENDED Vaccines		Enter complete date (mo/day/yr)				
Polio	OPV/IPV	1.	2.	3.	4.	5.
Measles/Mumps/Rubella	MMR	1.	2.			
Chickenpox	Varicella	1.	2.		or date of titer:	
					or date of disease:	
Hepatitis A	Hep A or Hep A/B	1.	2.	3.	or date of disease:	
Human Papilloma Virus	HPV 4- or 9-valent	1.	2.	3.		
Meningococcal serogroup B	Trumenba or Bexsero (circle)	1.	2.	3.		
Pneumococcal	PCV13 or PPSV23					
Influenza	TIV/LAIV					
Other						

Tuberculosis Screening (only if student at risk)

PPD or Date: _____ Result: ____ mm Negative () Positive ()

Quanti-FERON-TB Date: _____ Result: titer _____ Negative () Positive ()

If either test positive, CXR required: Date: _____ Results: Normal () Abnormal ()

Treatment: _____

To the best of my knowledge, the person named above has received the immunizations listed on this form.

HEALTH CARE PROVIDER SIGNATURE

Printed Name _____ Signature _____ Date _____

Address _____ City/State _____ Zip code _____ Phone Number _____

Emergency Information

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Name: _____
Last First Middle I.

SS#: _____ Date of Birth: ____/____/____

Emergency Contact Information - In case of emergency, please contact:

Family Member: _____ Relationship: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

INSURANCE: (Be sure to bring your insurance card with you when you begin classes. Also, submission of this information **does NOT constitute a waiver** of the University Health Insurance.)

[Note: Full disclosure is important for proper care in case of emergency. All information is kept confidential.]

Subscriber: _____ Subscriber SSN: _____

Name of Insurance: _____ Subscriber D.O.B. ____/____/____

Policy/ ID #: _____ Group#: _____

Co-insurance? Yes No Co-pay? Yes No Co-pay required for outpatient visit \$ _____

Please attach **front and back copy** of insurance card.

Allergies (medicine, food, insects, etc.) _____

Medical Conditions: (allergies, diabetes, heart disease, depression, anxiety, asthma, etc.)

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Current Medications/Supplements:

1. _____ For: _____ How long? _____

2. _____ For: _____ How long? _____

3. _____ For: _____ How long? _____

4. _____ For: _____ How long? _____

5. _____ For: _____ How long? _____

6. _____ For: _____ How long? _____

PARENT/GUARDIAN MEDICAL RELEASE (Must be completed for students under 18 years of age.)

I give permission for diagnostic, therapeutic, and/or operative procedures, should an emergency arise. In such an instance, the University of Dallas, through its physician or other medical authority, may act with my approval in treating my son/daughter/ward.

Signature: _____ Date: _____