# 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 January 1, 2020**. For students confirming after January 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. February 10, 2020 is the spring 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 December 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.

UNIVERSITY OF DALLAS

# Personal & Family History

Page 1 of 4:
University of Dallas Health Form

**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): | |
| | | | | | | Diabetes: | |
| Sisters | | | | | | 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/ Uncorrected Vision

R20/ L20/ Corrected Vision

[ ] Yes [ ] No 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

Rev. 10/2018

# 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:** _____