DBU

Report of Medical History

Students are required to have a current Report of Medical History if they plan to live in university housing. These records can be obtained from the high school, college or university previously attended, a private physician, public health records, and/or military records.

What immunizations do you need?

1. The **Tetanus-Diphtheria and Pertussis (Tdap)** vaccination is required every ten years. It is very important that the student is up to date on this vaccination because if any injury occurs (i.e., stepping on a rusty nail, being bitten by an animal, being involved in an auto accident) the student could contract Lock Jaw or Tetanus. The Tdap could prevent these illnesses as well as diphtheria and whooping cough.

2. The **Measles, Mumps, and Rubella (MMR)** You must have record of two doses of MMR before you can move in.

3. The **Tuberculosis Skin Test (TBST)** or a chest x-ray must be done every two years. Tuberculosis is a very contagious airborne disease, contracted when a person with active TB coughs, speaks, or sneezes and is inhaled by another person. DBU uses the Mantoux method because it is more accurate than other kinds of tests. If the TBST is positive, the student must have a chest x-ray. Results must be received in the Residence Life Office before you can move in.

4. The **Meningitis** vaccine protects against meningococcal disease, a rare, but potentially fatal, bacterial infection. Due to lifestyle factors, such as close living situations, irregular sleep patterns, and shared personal items, college students living in residence halls are more susceptible to meningococcal disease than the general population.

Although they are not required, we recommend that you also have the following immunizations: Hepatitis A, Hepatitis B, and Fluzone (Flu - annually).

For current immunization prices please contact Health Services at (214) 333-5151.

These immunizations must be current and complete **before** the student moves into university housing. If you have questions about your health form, please call Health Services at (214) 333-5151.

Please Print Student's Name _____ DBU ID#_____

A. Tetanus-Diphtheria-Pertussis

1. Received Tdap within the last 10 years ____ /____/____

B. MMR (Measles, Mumps, and Rubella) *Students who are 35 years of age or older may have the MMR requirements waived.*

1. ❑ Dose 1 Typically around 12 months of age ____ /____/____
2. ❑ Dose 2 After the 4th birthday ____ /____/____

C. Tuberculosis - check appropriate box

1. ❑ PPD (Mantoux or Tine) test within the past two years (monovac not acceptable)
   - Result: ❑ Positive ❑ Negative ____ /____/____
   - Result: ❑ Positive ❑ Negative ____ /____/____
   - Result: ❑ Positive ❑ Negative ____ /____/____
   - Result: ❑ Positive ❑ Negative ____ /____/____
2. ❑ Positive PPD - chest x-ray required. Give date and result of chest x-ray
   - Result: ❑ Positive ❑ Negative ____ /____/____
   - Result: ❑ Positive ❑ Negative ____ /____/____
   - Result: ❑ Positive ❑ Negative ____ /____/____
   - Result: ❑ Positive ❑ Negative ____ /____/____

D. Meningitis (one of the following is required)

- ❑ Menactra (within the last 5 years) ____ /____/____
- ❑ Menveo (within the last 5 years) ____ /____/____
- ❑ MCV4 (within the last 5 years) ____ /____/____

E. Polio (not required if 18 years of age or older)

Completed primary series of polio immunization

Type of vaccine: ❑ Oral ❑ Inactivated ❑ E-IPV ____ /____/____

Recommended, but not required.

Hepatitis A
- ❑ Dose 1 Date ____ /____/____
- ❑ Dose 2 Date ____ /____/____

Hepatitis B
- ❑ Dose 1 Date ____ /____/____
- ❑ Dose 2 Date ____ /____/____
- ❑ Dose 3 Date ____ /____/____

Twinrix (Hep A & B Combined)
- ❑ Dose 1 Date ____ /____/____
- ❑ Dose 2 Date ____ /____/____
- ❑ Dose 3 Date ____ /____/____

Fluzone (Flu - annually)
- ❑ Date ____ /____/____
- ❑ Date ____ /____/____
- ❑ Date ____ /____/____

Examining Physician- Please print information

Name _____ Title _____ Phone Number (_____) _____ - _____

Signature _____ Address _____

Student Treatment Consent and Release

In case of illness or accident, I give Dallas Baptist University and its representative(s) full permission to secure medical, dental, and / or surgical care which may include transportation to a doctor or hospital of their choice, injections, examination, medication, and surgery that is considered necessary for my good health. I agree to pay all off-campus medical costs and fees, including costs and fees for all emergency medical treatment and transportation. In the event of a less serious condition requiring minor care, I approve of care under the physician's standing order for Dallas Baptist University. In all events, I understand and agree that Dallas Baptist University does not have any liability or responsibility for any injury or damage which may arise from such medical, dental, and / or surgical care. ❑ Agree ❑ Disagree

_____ _____

Signature of Student *Parent's or Guardian's Signature if student is under 18 years of age*

Notice: This Report of Medical History must be completed and signed by both the student and the examining physician.

Please return to Dallas Baptist University / Residence Life Office / 3000 Mountain Creek Parkway / Dallas, TX 75211-9299

DBU

Office Use Only

Date Received: _____
DBU ID#: _____

Report of Medical History

Important Notice: This entire form must be completed and returned to the DBU Residence Life Office. A completed Report of Medical History is a prerequisite for living in the residence halls or Colonial Village Apartments. This information will be used solely as an aid in providing necessary health care while you are a student.

Personal Information

First Semester of Enrollment: ❑ Fall ❑ Spring ❑ Summer ❑ Winter 20___

Applying as: ❑ Freshman ❑ Sophomore ❑ Junior ❑ Senior ❑ Graduate ❑ International Student

Last _____ First _____ MI _____ ❑ M ❑ F

Address _____ Date of Birth ____/____/____

City _____ State _____ ZIP _____ E-mail _____

Home Phone Number (_____) _____ - _____

Cell Phone Number (_____) _____ - _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed Country of Citizenship _____

Have you previously been a residential student at DBU? ❑ Yes ❑ No If so, what semester and year? _____

Parent(s) or legal guardian(s) name(s) _____

Address and telephone number, if different than above _____

Home Number (_____) _____ - _____ Work Number (_____) _____ - _____ Other Number (_____) _____ - _____

Health Insurance Company _____ Policy Number _____

Medical Information

Please answer all questions. Comment on all positive answers in this section, using the back of this sheet with certifying signature.

Have you ever had	Yes	No		Yes	No		Yes	No		Yes	No
01 Scarlet Fever	❑	❑	12 Frequent anxiety	❑	❑	22 Allergy	❑	❑	28 High / low blood pressure	❑	❑
02 Measles	❑	❑	13 Frequent depression	❑	❑	a. Penicillin	❑	❑	29 Rheumatic fever or	❑	❑
03 German Measles(rubella)	❑	❑	14 Worry or nervousness	❑	❑	b. Sulfonamides	❑	❑	heart murmur	❑	❑
04 Mumps	❑	❑	15 Mental illness	❑	❑	c. Serum	❑	❑	30 Tumor, cancer, cyst	❑	❑
05 Chicken Pox	❑	❑	16 Recurrent colds	❑	❑	d. Foods	❑	❑	31 Chest pain / pressure	❑	❑
06 Diabetes	❑	❑	17 Head injury w/	❑	❑	e. Other	❑	❑	32 Weakness / paralysis	❑	❑
07 Malaria	❑	❑	unconsciousness	❑	❑	23 Dizziness, fainting	❑	❑	33 Venereal disease	❑	❑
08 HIV (tested positive)	❑	❑	18 Epilepsy, convulsions	❑	❑	24 Chronic cough	❑	❑	34 Frequent urination	❑	❑
09 Tuberculosis	❑	❑	19 Asthma	❑	❑	25 Heart palpitations	❑	❑	35 Severe cramps	❑	❑
10 Insomnia	❑	❑	20 Shortness of breath	❑	❑	26 Hearing impairment	❑	❑	36 Recent gain / loss of		
11 Hepatitis	❑	❑	21 Hay Fever	❑	❑	27 Visual impairment	❑	❑	weight	❑	❑

	Yes	No
A. Has your physical activity been restricted during the past five years?	❑	❑
B. Have you had difficulty with school, studies, or teachers?	❑	❑
C. Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem?	❑	❑
D. Have you had an illness or injury or been hospitalized other than already noted?	❑	❑
E. Do you need to take any medication by prescription? If so, list on the back.	❑	❑
F. Are you currently taking any other medications? If so, list on the back.	❑	❑
G. Have you been rejected or discharged from military service because of physical, emotional, or other reason?	❑	❑
H. Do you have questions in regard to your health, family history, or other matters, such as pre-marital counseling, which you would like to discuss with a member of the staff of the Health Center, or Counseling Center?	❑	❑

I certify all questions have been answered correctly and completely. _____
Student's Signature

Name: _____ DBU #_____

Please detail any positive answers from the previous page in the section below.

Use this section for questions 1 - 36

Number Date Details

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Use this section for questions A - H

Letter Date Details

_____

_____

_____

_____

_____

_____

_____

_____

I certify all questions have been answered correctly and completely. _____
Student's Signature

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