BAYLOR UNIVERSITY
LOUISE HERRINGTON SCHOOL OF NURSING
3700 Worth Street • Dallas, TX 75246
Phone: (214) 820-3361 • Fax: (214) 818-8692

STUDENT HEALTH HISTORY AND IMMUNIZATION RECORD

_____
Student's ID#

PERSONAL INFORMATION

Student's Name _____
Student's Cell Phone (_____) _____
Address _____
City/State/Zip _____
Date of Birth _____/_____/_____ Country of Birth _____
Date of Initial Baylor Enrollment: Semester _____ Year _____

EMERGENCY INFORMATION

Person to Notify in an Emergency _____
Relationship _____
Primary Phone (_____) _____
Secondary Phone (_____) _____
Emergency Email Contact _____
Program: ☐ Undergraduate ☐ Fast BACC ☐ Graduate

TUBERCULOSIS TEST

Skin Test Date Administered _____/_____/_____ Date Read _____/_____/_____ Result: Pos. / Neg. *Circle One* induration _____ mm Must complete *(ie. 0mm, 2mm, ...)*

-or- TB Blood Test (Tspot TB or Quantiferon Gold) Date Read _____/_____/_____ Result: Pos. / Neg. *Circle One*

Chest X-ray (required if skin test is positive) Date Read _____/_____/_____ Result: Pos. / Neg. *Circle One*
*If skin test is positive but subsequent blood test is negative, chest x-ray is not required.

IMMUNIZATION RECORDS

Flu Vaccine Date Administered _____/_____/_____ Lot# _____ Manufacturer _____

Meningococcal Vaccine: (Texas State law requires this for new students under age 22) MPSV or MCV4 *Circle One* Date Administered _____/_____/_____

Hepatitis B: Dose #1 Date _____/_____/_____ Dose #2 Date _____/_____/_____ Dose #3 Date _____/_____/_____
-or- Titer Date _____/_____/_____ Titer Results: Pos. / Neg. (If negative booster required) *Circle One*

Varivax (Chickenpox Vaccine): *If born before 1980 and had disease,Varivax requirement waived.* Disease Date _____/_____/_____
Dose #1 Date _____/_____/_____ Dose #2 Date _____/_____/_____
-or- Titer Date _____/_____/_____ Titer Results: Pos. / Neg. *Circle One*

TDAP Date Administered _____/_____/_____

Measles, Mumps and Rubella (German Measles):
MMR Dose #1 Date _____/_____/_____ MMR Dose #2 Date _____/_____/_____ **-or-** Measles: Date _____/_____/_____
-or- Titer Date _____/_____/_____ Titer Results: Pos. / Neg. *Circle One*

Copies of Official Immunization Records Required
All records must be signed by the physician or clinician who administered vaccine.

The following documents cannot be accepted as official immunization records.

- High School Nurses Records – even if signed by physician
- High School Transcript
- University/College Records – except for Baylor Health Center records
- Cash register receipts

Student Name_____ Date of Birth_____

MEDICAL HISTORY Have you been treated for:

Allergies to Medication: ☐ Yes ☐ No If Yes, please list and explain reaction(s) _____

_____

	YES	NO		YES	NO		YES	NO
ADD/ADHD			Eating Disorder			MRSA		
Anemia			Eye Disorder			Pain/Pressure in Chest		
Anxiety			Head Injury			Peptic Ulcer		
Arthritis			Hearing Difficulty			Recent Weight Change		
Asthma			Heart Disorder			Seizure Disorder		
Back Injury			Hepatitis			Shortness of Breath		
Bleeding Disorder			Hernia			Sinusitis		
Bone or Joint Disease			High Blood Pressure			STD		
Cancer			Irritable Bowel Syndrome			Tuberculosis		
Chickenpox			Infectious Mononucleosis			**Surgery:**		
Depression			Irregular Sleep Patterns			Appendectomy		
Diabetes			Kidney/Bladder Disease			Tonsillectomy		
Dizziness, Fainting			Migraine Headaches			Hernia Repair		
Ear, Nose, Throat Disorder			Menstrual Disorder			Other Surgeries:		

Give Details Of Positive (Yes) Answers _____

_____

Other Condition(s) Not Listed _____

_____

_____

Have You Received Treatment or Counseling from a Mental Health Care Provider? ☐ Yes ☐ No If Yes, please explain _____

_____

Health Care Provider Completes

PHYSICAL EXAMINATION (Within past 12 months)

Temperature _____ Blood Pressure_____ Pulse _____ Height_____ Weight _____

Check - normal	YES	NO		YES	NO		YES	NO	If answer is "No" explain below
Development			Tonsils			Abdomen			
Posture			Neck			Genitalia (*Optional*)			
Skin			Thyroid			Upper Extremity			
Ears			Chest			Lower Extremity			
Eyes			Heart			Bones and Joints			
Nose			Lungs			Feet			
Mouth			Breasts (*Optional*)						

Restrictions/Limitations? ☐ Yes ☐ No

Comments _____

_____

Signed (*Health Care Provider*) _____ Date _____

Print Name _____ Phone (_____) _____

Address _____ Fax (_____) _____

STUDENT'S SIGNATURE

Federal or state law limits the use and release of student medical records; gives students the right to access education records; restricts most disclosure of health information; and establishes safeguards regarding disclosure of records for certain public responsibilities, such as public health, research and law enforcement. Improper use or disclosure of patient information may be subject to criminal or civil sanctions. Questions or concerns regarding release/disclosure of health information should be directed to the School of Nursing at (214) 820-3361.

☐ I certify that the information I have provided is accurate and complete.

Signed (Student Signature) _____

☐ I give authorization for release/disclosure of my health information necessary for use by clinical agencies unless revoked in writing.

(PLEASE COMPLETE BOTH SIDES.
Important: Retain copies of both sides of this form for your records.)

BAYLOR UNIVERSITY

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