



HEALTH FORM

RETURN THIS FORM TO:

Baylor University Health Services

ATTN: Health Form • One Bear Place #97060 • Waco, TX 76798-7060

Phone: (254) 710-1010 • Fax: (254) 710-2499 • Email: Health_Services@baylor.edu

Student Completes

Name: _____
Please Print (Last) (First) (Middle)

SSN: _____ - _____ - _____ Date of Birth: ____/____/____ Country of Citizenship: _____

Address: _____
Number and Street City State ZIP

Telephone: (____) _____ Sex: **F M** Marital Status: _____
Circle One

Parent(s) Name: _____ Parent(s) Phone: Home (____) _____ Work (____) _____

Medical Insurance Company _____ Group No. _____ Policy No. _____

If previously attended Baylor, please give the semester and year of last attendance: _____

Enrolling: ____ Year Fall Spring Summer I Summer II

Applying for admission to: Undergraduate School Graduate School Law School Nursing School, Dallas Campus Truett Seminary Other Non-Waco Campus

Are you a Military Veteran? Yes No Date of Discharge _____

Are you currently in the Military? Yes No

Are you a Military Dependent? Yes No

Immunization Requirements

<p>Tetanus-Diphtheria</p> <p>Series completed _____ <i>Date</i></p> <p>TD Booster/TDaP* _____ <i>(circle one) (within 10 years)</i></p> <p>*Required by Nursing School</p>	<p>MMR <i>(Measles, Mumps, Rubella)</i></p> <p>1st immunization: _____ <i>Date</i></p> <p>and</p> <p>2nd immunization: _____ <i>Date</i></p>	<p>HEP B Series*</p> <p>_____ <i>Date</i></p> <p>_____ <i>Date</i></p> <p>_____ <i>Date</i></p> <p>*Required by Nursing School</p>	<p>Polio</p> <p>Completed primary series _____ <i>Date</i></p>
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Other Immunizations

<p>Varicella Vaccine Dates Given _____</p> <p>_____</p> <p>Meningitis Date Given _____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>PPD</p> <p>Required within last 12 months</p> <p>PPD Skin Test: _____ <i>Date Given</i></p> <p>Mantoux Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive _____ <i>Date Read</i></p> <p>If positive-induration _____ <i>mm.</i></p> <p>or TB (Blood Test) _____ <i>Result Date</i></p> <p>If PPD Results are Positive, a Chest X-Ray is Required</p> <p>Chest X-Ray for Tuberculosis screening _____ <i>Date</i></p> <p>Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive</p>
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Signature and date of physician or other healthcare provider authenticating immunizations
(Please place physician or healthcare provider address or stamp above.)

Student or Parent Completes

FOR ALL STUDENTS UNDER 18 YEARS OF AGE: I authorize the Baylor University Student Health Center to administer medical and surgical services, immunizations, and therapeutic procedures as deemed necessary by duly licensed personnel.

(Parent's or Guardian's Signature) (Date)

FOR ALL STUDENTS: By signature, I verify that the information provided on this form is true and I give permission for such diagnostic, therapeutic, and operative procedures as may be deemed necessary for me.

(Student's Signature) (Date)

Last Name _____ First Name _____ Middle _____ Date of Birth _____

MEDICAL HISTORY Have you been treated for:

	YES	NO		YES	NO		YES	NO		YES	NO
ADD/ADHD			Eating Disorder			MRSA			Allergy:		
Anemia			Eye Disorder			Pain/Pressure in Chest			Aspirin		
Anxiety			Head Injury			Peptic Ulcer			Codeine		
Arthritis			Hearing Difficulty			Recent Weight Change			Penicillin		
Asthma			Heart Disorder			Seizure Disorder			Sulfa		
Back Injury			Hepatitis			Shortness of Breath			Latex		
Bleeding Disorder			Hernia			Sinusitis			Wasp/Bee Stings		
Bone or Joint Disease			High Blood Pressure			STD			Foods (specify)		
Cancer			IBS			Tuberculosis			Other Allergies:		
Chicken Pox			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:		

Other condition(s) not listed: _____

Give details of positive (Yes) answers: _____

Have you received treatment or counseling from a mental healthcare provider? Yes No If Yes, please explain: _____

Current Medications (Please List) _____

PHYSICAL EXAMINATION (Within past 12 months)

Temperature _____ Blood Pressure _____ Pulse _____ Height _____ Weight _____

Vision (without correction) Rt _____ Left _____ (with correction) Rt _____ Left _____ LMP _____

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: _____ Date: _____
Physician Signature

Print Name: _____ Phone: (____) _____

Address: _____ Fax: (____) _____

(Please complete both sides. Important: Retain copies of both sides of this form for your records.)

