BAYLOR
UNIVERSITY

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
E-mail: HealthServices@baylor.edu

HEALTH FORM

This form must be submitted and approved prior to confirmation of an Orientation session or registration for classes.

STUDENT COMPLETES

Name: (Please Print) _____
LAST *FIRST* *MIDDLE*

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

Address: _____
NUMBER AND STREET *CITY* *STATE* *ZIP*

Telephone: _____ Sex: ❑ Male ❑ Female Marital Status: _____ No. of Children: _____

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

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

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

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

Enrolling: _____ Year ❑ Fall ❑ Spring ❑ Summer I ❑ Summer II

Attending: ❑ Full-time (12 hours or more) ❑ Part-time (11 hours or less)

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

HEALTH CARE PROVIDER COMPLETES

ALL ENTERING STUDENTS

Tetanus-Diphtheria
Immunization: _____
DATE WITHIN 10 YEARS

PPD Skin Test: _____
DATE

Mantoux
WITHIN PAST
12 MONTHS _____
DATE

_____
DATE

Result: ❑ Neg. ❑ Neg. ❑ Neg.
❑ Pos. ❑ Pos. ❑ Pos.

ALL STUDENTS BORN ON or AFTER JANUARY 1, 1957

Measles (Rubeola) after 1980
1st immunization: _____
and *DATE*
2nd immunization: _____
AFTER 1980 *DATE*
or
Date of Disease: _____
or *DATE*
Immune Titer: _____
DATE

_____
_____
RESULT OF TITER

Mumps
Immunization: _____
DATE
or
Date of Disease: _____
or *DATE*
Immune Titer: _____
DATE

_____
_____
RESULT OF TITER

Rubella (German Measles)
Immunization: _____
DATE
or
Date of Disease: _____
or *DATE*
Immune Titer: _____
DATE

_____
_____
RESULT OF TITER

IF PPD RESULTS POSITIVE, A CHEST X-RAY IS REQUIRED

Chest X-Ray (full-sized, posteroanterior) for Tuberculosis screening
_____ Result: ❑ Neg. ❑ Pos.
DATE

OTHER IMMUNIZATIONS

_____ Date Given _____
_____ Date Given _____
_____ Date Given _____

ALL STUDENTS UNDER AGE 19

Polio: Completed Primary Series _____
DATE

_____
Signature and date of physician or other health care provider authenticating immunizations
(PLEASE PLACE PHYSICIAN OR HEALTH CARE 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*

IMPORTANT: Make a copy of this form for your personal records

LAST FIRST MIDDLE SOCIAL SECURITY NUMBER

Medical History

STUDENT COMPLETES

HAVE YOU HAD?	Y	N	HAVE YOU HAD?	Y	N	HAVE YOU HAD?	Y	N	HAVE YOU HAD?	Y	N
Allergy:			Cancer			Hepatitis			Recurrent Diarrhea		
Penicillin			Chicken Pox			Hernia			Recurrent Headaches		
Sulfa			Chronic Cough			High or Low Blood Pressure			Scarlet Fever		
Codeine			Diabetes			Infectious Mononucleosis			Seizures/Blackouts		
Aspirin			Dizziness, Fainting			Irregular Sleep Patterns			Shortness of Breath		
Wasp/Bee Stings			Ear, Nose, Throat Trouble			Kidney/Bladder Disease			Sinusitis		
Foods (which)			Eating Disorder			Measles (Rubeola)			Stomach Trouble		
Other Allergies			Epilepsy			Menstrual Disorder			Surgery:		
			Eye Trouble			Mumps			Appendectomy		
Appendicitis			Frequent Anxiety			Nervous Breakdown			Tonsillectomy		
Arthritis			Frequent Depression			Pain/Pressure in Chest			Hernia Repair		
Asthma			German Measles (Rubella)			Peptic Ulcer			Other Surgeries:		
Back Injury			Head Injury			Polio					
Bleeding Disorder			Hearing Difficulty			Recent Weight Change			Tuberculosis		
Bone or Joint Disease			Heart Trouble			Recurrent Colds			Venereal Disease		

Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem? Please provide details.

Physical Examination

HEALTH CARE PROVIDER COMPLETES

ALL FULL-TIME UNDERGRADUATE STUDENTS, *NOT REQUIRED FOR PART-TIME OR GRADUATE LEVEL STUDENTS*

Temperature _____ Blood Pressure _____ Pulse _____ Height _____ Weight _____

Vision: (*WITHOUT GLASSES*) Right _____ Left _____ Vision: (*WITH GLASSES*) Right _____ Left _____ Hearing: Right _____ Left _____

CHECK-Normal	Y	N	CHECK-Normal	Y	N	CHECK-Normal	Y	N	If answer is "No", explain below:
Development			Tonsils			Abdomen			
Posture			Neck			Genitalia			
Skin			Thyroid			Upper Extremity			
Ears			Chest			Lower Extremity			
Eyes			Heart			Bones and joints			
Nose			Lungs			Feet			
Mouth			Breasts						

Routine Urinalysis _____ Albumin _____ Sugar _____ Microscopic _____

1. Current medications (Please list): _____

_____

2. Activity limitations? _____

3. Is patient ready to undertake college activities? ❑ Yes ❑ No If "No", please explain. _____

_____

Comments: _____

_____

_____

Signed: _____ Date: _____

PHYSICIAN SIGNATURE

Address: _____ Telephone (with area code): _____