BAYLOR UNIVERSITY

Student ID# _____

☐ Complete Health Form
☐ Incomplete for _____
_____
☐ Letter or Email Sent on _____
(For Office Use Only)

# HEALTH FORM

**RETURN THIS FORM BY FAX OR EMAIL OR MAIL:**

**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

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

Date of Birth: _____/_____/_____ Country of Citizenship: _____

Address: _____
*Number and Street City State ZIP*

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

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

Medical Insurance Company _____ Insured's Name _____
(Attach copy of front and back of insurance card)

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

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

Applying for admission to:
☐ Undergraduate School ☐ Law School ☐ Truett Seminary
☐ Graduate School ☐ Nursing School, Dallas Campus ☐ _____ Other

## 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 | | | Tuberculosis | | | Foods (specify) | | |
| Cancer | | | Irritable Bowel Syndrome | | | | | | 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*) _____ _____ _____
_____ _____ _____

**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:** Copy both sides of this form for your personal records. (over)

Name: _____ Date of Birth: _____/_____/_____
*Please Print (Last) (First) (Middle)*

**Attach copy of official immunization record**

**REQUIRED IMMUNIZATIONS FOR ALL STUDENTS (Attach legible copy of official immunization record)**

1. **Tetanus-Diphtheria:**

   TD Booster / Tdap _____/_____/_____
   *Circle One (Within 10 Years)*

2. **MMR (Measles, Mumps, Rubella)** (Both doses must be after 1st birthday):

   1st immunization _____/_____/_____
   *Date*

   2nd immunization _____/_____/_____
   *Date*

3. **Meningococcal Meningitis** (Texas State law requires this for new students under age 22.):

   Menactra / Menveo _____/_____/_____
   *Circle One (Within 5 Years)*

(Only necessary if official copy is not attached) _____
*Health Care Personnel Signature* *Date*

**Health care personnel must sign if you answer "Yes" to any question**

**TB TESTING - All students must answer the following questions:**

1. Were you born outside the United States? ☐ Yes ☐ No
2. Have you lived outside the United States for more than 8 weeks continuously? ☐ Yes ☐ No
3. Do you have a medical condition that suppresses the immune system? ☐ Yes ☐ No
4. Have you had a known exposure to someone with active tuberculosis? ☐ Yes ☐ No

**If ANY answers to the above questions are "Yes", the following MUST be filled out and signed by health care personnel**

Skin test (Mantoux) within last 12 months _____/_____/_____ _____/_____/_____
*Date Given* *Date Read*

Results: Negative / Positive (10mm or greater)
*Circle One*

If positive, induration _____mm

**OR**

TB blood test (Tspot TB or Quantiferon Gold) _____ _____/_____/_____
*Circle One* *Result* *Date*

Treated with INH? ☐ Yes ☐ No If yes, how long? _____

**If either TB test result is positive, a chest x-ray is required***

Chest x-ray: _____/_____/_____ Results: Negative / Positive
*Date* *Circle One*

*If skin test is positive but subsequent blood test is negative, chest x-ray is not required.

_____
*Health Care Personnel Signature* *Date*

**Baylor University Health Services**
www.baylor.edu/health_center

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