McMurry University

Report of Medical History and Consent of Medical Treatment

Complete and Mail to:
Campus Nurse
1 McMurry University # 716
Abilene TX 79697 - 0001
Phone: 325 - 793 - 4857
Fax: 325 - 793 - 4879

Name (Last, First, Middle)				Student Identification Number
Home Address (Number and Street, City, State, Zip)				Area Code & Telephone No. (student)
Date of Birth	Age	Sex ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ Other	Citizenship

Person to notify in case of illness, injury, or emergency: Name, Relationship, Street Address

City, State, Zip	Home Telephone No.	Business Telephone No. or Cell No.

PROOF OF THE FOLLOWING 2 IMMUNIZATIONS IS REQUIRED BY McM PRIOR TO REGISTRATION
May send copy of official immunization record.

* **BACTERIAL MENINGITIS Vaccine**

Must submit evidence of the vaccination. Acceptable evidence includes the following:

- The signature or stamp of a physician or his/her designee, or public health personnel, on a form which shows the month, day, and year the vaccination dose or booster was administered.
- An official immunization record generated from a state or local authority.
- An official record received from school officials, including a record from another state.

Available exemptions;

- Is 22 years of age or older on or before the first day of the term enrollment.
- Signs an affidavit declining the vaccination. Request must be made through the Department of State Health Services.
- Presents a physician's certificate indicating the vaccination would injure the health of the student.

* **MMR (Measles, Mumps, and Rubella)** Two injections since age one required.

All students

Acceptable proof is considered to be:

- An official immunization record generated from a state or local authority or school.
- Record of immunization signed by personal physician
- Documentation of disease by a physician
- Document indicating protective titer.

Available exemptions:

- Presents a physician's certificate indicating the vaccination would injure the health of the student.

* **TUBERCULOSIS** (See Tuberculosis Screening Questionnaire), If any questions answered yes, then a Negative Test OR Chest X-Ray is required **within Past One Year**.

Consent to Medical Treatment - **If signed by parent/guardian, authorization is only good until student reaches his/her 18th birthday. **

I authorize the Campus Nurse and/or consultants to administer medical services and immunizations, and to perform emergency and therapeutic procedures, as necessary, or refer to licensed medical personnel when indicated (including to nearby hospitals).

Signature of Student if 18 years or over Date

Signature of Parent or Guardian if Student is under 18 Date

PERSONAL HISTORY

Please answer all questions. Comment on all positive answers in space below.

Have you had or have you now?

	YES	YEAR	NO		YES	YEAR	NO		YES	YEAR	NO		YES	YEAR	NO
German Measles, Rubella				Head injury with unconsciousness				Rheumatic Fever or Heart Murmur				Albumin/Sugar in Urine, **Diabetes**			
Measles				Dizzy Spells, Fainting				Heart Disease				Kidney Disease			
Mumps				Weakness, Paralysis				High Blood Pressure				Frequent Urination			
Chicken Pox				Tuberculosis				Pain/Pressure in Chest				Inf. Mononucleosis			
Epilepsy, Convulsions				Asthma				Chronic Cough				Inf. Hepatitis			
Eye trouble				Shortness of Breath				Rupture, Hernia				**Other Medical Condition Or Surgery List**:			
Ear, Nose, Throat trouble				Disease/Injury of Joints, Back				Stomach/Intestine Trouble							
Insomnia				**ALLERGY**				Gall Bladder Trouble or Gallstones							
Frequent Anxiety				Penicillin											
Frequent Depression				Sulfonamides				Recurrent Diarrhea				**FEMALES ONLY**	YES	YEAR	NO
Worry or Nervousness				Serum				Recent Gain or Loss of weight				Irregular Periods			
Recurrent Headaches				Foods								Severe Cramps			
Recurrent Colds				Others: List								Excessive Flow			
Tumor, Cancer, Cyst												Pap Smear Date:			
Venereal Disease												Results:			

Comments/Medications:

FAMILY HISTORY

	AGE	OCCUPATION	AGE @ DEATH	CAUSE OF DEATH
Father				
Mother				
Brothers				
Sisters				

List details below to YES responses	YES	NO
A. Has your physical activity been restricted during the past five years?		
B. Have you ever received treatment or counseling for a nervous condition, personality, or character disorder, or emotional problem?		
C. Do you take any prescription medications?		

Comments:

Student Signature. I certify all questions are answered accurately.

ACKNOWLEDGEMENTS:

- I understand that health insurance is required to attend McMurry University. McMurry is not responsible for any expenses that incur from injury or illness that occur on or off campus. Please supply a copy of the front and back of your insurance card.

  Signature_____ Date_____

- Please sign below that you received written information about Bacterial Meningitis with this form:

  Signature_____ Date_____

- I acknowledge that I have received the Notice of Privacy Practices and authorize McMurry to discuss my PHI with the following individuals:

Name Relationship Phone #

Name Relationship Phone #

Signature of Student or Legal Representative Date

Printed Name of Student or Legal Representative Relationship to Student

Revised 2021