McMurry University International

Report of Medical History and Consent of Medical Treatment

Complete and Mail to:
Campus Nurse
1 McMurry University # 716
Abilene TX 79697 - 0716
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 4 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.

BACTERIAL MENINGITIS VACCINE - DATE_____

* **TUBERCULOSIS** (See Tuberculosis Screening Questionnaire), If any questions answered yes, then a negative test OR chest x-ray is required **within Past One Year**.

TB SKIN TEST Date _____ Results _____

CHEST X-RAY Date _____ Results _____

Have you ever had BCG vaccine? If yes, date _____

* **TETANUS/DIPTHERIA** Booster within 10 Years Date _____

HEPATITIS B Vaccine

DOSE #1 Date _____

DOSE #2 Date _____

DOSE #3 Date _____

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

DOSE #1 Date _____

DOSE #2 Date _____

ALL STUDENTS BORN AFTER 1957 MUST PROVIDE PROOF OF IMMUNITY TO MEASLES, MUMPS, AND RUBELLA.

ACCEPTABLE PROOF IS CONSIDERED TO BE:

1. RECORD OF IMMUNIZATION SIGNED BY PERSONAL PHYSICIAN.
2. DOCUMENTATION OF DISEASE BY A PHYSICIAN.
3. PROTECTIVE TITER.

AUTHORIZED SIGNATURE:

PHYSICIAN, PUBLIC HEALTH CLINIC, OR TRANSCRIPT FROM SCHOOL RECORDS

Signature _____

Title _____

Address _____

City, State, Zip _____

Telephone No. _____ Fax No. _____

RECOMMENDED (But Not Required)

Hepatitis A Vaccine

DOSE #1 Date _____ DOSE #2 Date _____

Please List Allergies: Drugs:

_____ _____

_____ _____

_____ _____

_____ _____

Consent to Medical Treatment

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.

I understand that international students attending McMurry University will be required to show proof of health insurance or the student will be required to purchase insurance through the university and the charges will be applied to the student's account.

Signature_____ Date_____

Please sign below that you received written information about Bacterial Meningitis:

Signature_____ Date_____

McMurry University

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Tuberculosis Screening Questionnaire

Part I: Tuberculosis (TB) Screening Questionnaire (to be completed by incoming students)

Please answer the following questions:

Have you ever had close contact with persons known or suspected to have active TB disease? ☐ Yes ☐ No

Were you born in one of the countries or territories listed below that have a high incidence of active TB disease? (If yes, please CIRCLE the country, below.) ☐ Yes ☐ No

Afghanistan	China, Macao SAR	Honduras	Myanmar	South Africa
Algeria	Colombia	India	Namibia	South Sudan
Angola	Comoros	Indonesia	Nauru	Sri Lanka
Anguilla	Congo	Iraq	Nepal	Sudan
Argentina	Democratic People's	Kazakhstan	Nicaragua	Suriname
Armenia	Republic of Korea	Kenya	Niger	Tajikistan
Azerbaijan	Democratic Republic	Kiribati	Nigeria	Thailand
Bangladesh	of the Congo	Kuwait	Niue	Timor-Leste
Belarus	Djibouti	Kyrgyzstan	Northern Mariana Islands	Togo
Belize	Dominican Republic	Lao People's	Pakistan	Tokelau
Benin	Ecuador	Democratic Republic	Palau	Trinidad and Tobago
Bhutan	El Salvador	Latvia	Panama	Tunisia
Bolivia (Plurinational	Equatorial Guinea	Lesotho	Papua New Guinea	Turkmenistan
State of)	Eritrea	Liberia	Paraguay	Tuvalu
Bosnia and Herzegovina	Eswatini	Libya	Peru	Uganda
Botswana	Ethiopia	Lithuania	Philippines	Ukraine
Brazil	Fiji	Madagascar	Portugal	United Republic of Tanzania
Brunei Darussalam	French Polynesia	Malawi	Qatar	Uruguay
Bulgaria	Gabon	Malaysia	Republic of Korea	Uzbekistan
Burkina Faso	Gambia	Maldives	Republic of Moldova	Vanuatu
Burundi	Georgia	Mali	Romania	Venezuela (Bolivarian
Côte d'Ivoire	Ghana	Marshall Islands	Russian Federation	Republic of)
Cabo Verde	Greenland	Mauritania	Rwanda	Viet Nam
Cambodia	Guam	Mexico	Sao Tome and Principe	Yemen
Cameroon	Guatemala	Micronesia (Federated	Senegal	Zambia
Central African Republic	Guinea	States of)	Sierra Leone	Zimbabwe
Chad	Guinea-Bissau	Mongolia	Singapore	
China	Guyana	Morocco	Solomon Islands	
China, Hong Kong SAR	Haiti	Mozambique	Somalia	

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2018. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to http://www.who.int/tb/country/en/.

Have you had frequent or prolonged visits* to one or more of the countries or territories listed above with a high prevalence of TB disease? (If yes, CHECK the countries or territories, above) ☐ Yes ☐ No

Have you been a resident, volunteer, and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? ☐ Yes ☐ No

Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease? ☐ Yes ☐ No

Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol? ☐ Yes ☐ No

If the answer is YES to any of the above questions, McMurry University, requires that you receive TB testing as soon as possible but at least prior to the start of the subsequent semester.

If the answer to all the above questions is NO, no further testing or further action is required.

*The significance of the travel exposure should be discussed with a health care provider and evaluated.