Report of Medical History

Students are required to have a current Report of Medical History if they plan to live in university housing. These records can be obtained from the high school, college or university previously attended, a private physician, public health records, and/or military records.

What immunizations do you need?
1. The Tetanus-Diphtheria and Pertussis (Tdap) vaccination is required every ten years. It is very important that the student is up to date on this vaccination because if any injury occurs (i.e., stepping on a rusty nail, being bitten by an animal, being involved in an auto accident) the student could contract Lock Jaw or Tetanus. The Tdap could prevent these illnesses as well as diphtheria and whooping cough.

2. The Measles, Mumps, and Rubella (MMR) vaccine is required. You must have record of two doses of MMR before you can move in.

3. The Tuberculosis Skin Test (TBST) or a chest x-ray must be done every two years. Tuberculosis is a very contagious airborne disease, contracted when a person with active TB coughs, speaks, or sneezes and is inhaled by another person. DBU uses the Mantoux method because it is more accurate than other kinds of tests. If the TBST is positive, the student must have a chest x-ray. Results must be received in the Residence Life Office before you can move in.

4. The Meningitis vaccine protects against meningococcal disease, a rare, but potentially fatal, bacterial infection. Due to lifestyle factors, such as close living situations, irregular sleep patterns, and shared personal items, college students living in residence halls are more susceptible to meningococcal disease than the general population. Meningitis vaccine must have been renewed within the last 5 years.

Although they are not required, we recommend that you also have the following immunizations: Hepatitis A, Hepatitis B, and Fluzone (Flu - annually).

For current immunization prices please contact Health Services at (214) 333-5151.

These immunizations must be current and complete before the student moves into university housing. If you have questions about your health form, please call Health Services at (214) 333-5151.
A. Tetanus-Diphtheria-Pertussis
1. Received Tdap within the last 10 years ____ / ____ / ____

B. MMR (Measles, Mumps, and Rubella) Students who are 35 years of age or older may have the MMR requirements waived.
1. □ Dose 1 Typically around 12 months of age ____ / ____ / ____
2. □ Dose 2 After the 4th birthday ____ / ____ / ____

C. Tuberculosis - check appropriate box
1. □ PPD (Mantoux or Tine) test within the past two years (monovac not acceptable)
   Result: □ Positive □ Negative ____ / ____ / ____
   Result: □ Positive □ Negative ____ / ____ / ____
   Result: □ Positive □ Negative ____ / ____ / ____
   Result: □ Positive □ Negative ____ / ____ / ____
2. □ Positive PPD - chest x-ray required. Give date and result of chest x-ray
   Result: □ Positive □ Negative ____ / ____ / ____
   Result: □ Positive □ Negative ____ / ____ / ____
   Result: □ Positive □ Negative ____ / ____ / ____
   Result: □ Positive □ Negative ____ / ____ / ____

D. Meningitis (one of the following is required)
□ Menactra (within the last 5 years) ____ / ____ / ____
□ Menevo (within the last 5 years) ____ / ____ / ____
□ MCV4 (within the last 5 years) ____ / ____ / ____

E. Polio (not required if 18 years of age or older)
Completed primary series of polio immunization
Type of vaccine: □ Oral □ Inactivated □ E-IPV ____ / ____ / ____

Recommended, but not required.

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<td>□ Dose 2</td>
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<td>□ Dose 3</td>
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| Twinrix (Hep A & B Combined) |                  |                  |
|-----------------------------|------------------|
| □ Dose 1                    | Date ___/___/___  |
| □ Dose 2                    | Date ___/___/___  |
| □ Dose 3                    | Date ___/___/___  |

Examining Physician- Please print information
Name ________________________________ Title ____________________ Phone Number ( _____ ) _____ - _______
Signature ________________________________ Address ________________________________________________

Student Treatment Consent and Release
In case of illness or accident, I give Dallas Baptist University and its representative(s) full permission to secure medical, dental, and / or surgical care which may include transportation to a doctor or hospital of their choice, injections, examination, medication, and surgery that is considered necessary for my good health. I agree to pay all off-campus medical costs and fees, including costs and fees for all emergency medical treatment and transportation. In the event of a less serious condition requiring minor care, I approve of care under the physician’s standing order for Dallas Baptist University. In all events, I understand and agree that Dallas Baptist University does not have any liability or responsibility for any injury or damage which may arise from such medical, dental, and / or surgical care.
□ Agree □ Disagree

Signature of Student ____________________________ Parent’s or Guardian’s Signature if student is under 18 years of age ____________________________

Notice: This Report of Medical History must be completed and signed by both the student and the examining physician.

Please return to Dallas Baptist University / Residence Life Office / 3000 Mountain Creek Parkway / Dallas, TX 75211-9299 or scan and email to reslife@dbu.edu
### Personal Information

First Semester of Enrollment:  
- Fall  
- Spring  
- Summer  
- Winter  
- __20__

Applying as:  
- Freshman  
- Sophomore  
- Junior  
- Senior  
- Graduate  
- International Student

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Date of Birth ___/___/___

City _____________________  State ________  ZIP _____________  E-mail ______________________

Home Phone Number (_______) _______ - _______

Cell Phone Number (_______) _______ - _______

Country of Citizenship ______________________

Have you previously been a residential student at DBU?  
- Yes  
- No  
If so, what semester and year? ________________

Parent(s) or legal guardian(s) name(s) _______________________________________________________________

Address and telephone number, if different than above _______________________________________________________

Home Number (_______) _______  Work Number (_______) _______  Other Number (_______) _______

### Health Insurance Company ________________________________  Policy Number __________________________

### Medical Information

Please detail any positive answers from the above section.

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A. Has your physical activity been restricted during the past five years?  
B. Have you had difficulty with school, studies, or teachers?  
C. Have you received treatment or counseling for a nervous condition, personality or character disorder, or
D. Have you had an illness or injury or been hospitalized other than already noted?  
E. Do you need to take any medication by prescription? If so, list on the back.  
F. Are you currently taking any other medications? If so, list on the back.  
G. Have you been rejected or discharged from military service because of physical, emotional, or other  
H. Do you have questions in regard to your health, family history, or other matters, such as pre-marital like to discuss with a member of the staff of the Health Center, or Counseling Center?  

Please detail any positive answers from the above section.

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I certify all questions have been answered correctly and completely. ____________________________________________  
Student’s Signature

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