

# Comprehensive Student Health Form Form 1 of 2

Texas Lutheran University  
1000 W. Court St.  
Seguin, Texas 78155

Division of Student Life & Learning  
830-372-8060  
830-372-6412 – FAX

## Part I: General Information

All information disclosed on this form will be kept confidential and will be shared with appropriate University personnel only on a need-to-know basis. Please return your completed form to the Division of Student Life & Learning, using the enclosed envelope.

### Student Information

Name last \_\_\_\_\_ first \_\_\_\_\_ m.i. \_\_\_\_\_ Sex M \_\_\_\_\_ F \_\_\_\_\_

Address street \_\_\_\_\_ city \_\_\_\_\_ state \_\_\_\_\_ zip \_\_\_\_\_

Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Social Security Number \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Marital Status \_\_\_\_\_ # of Children \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Place of Birth city \_\_\_\_\_ state \_\_\_\_\_ Country \_\_\_\_\_

### **Parent/Guardian Consent** *Required only if student will be under 18 years old at time of enrollment.*

With the understanding that every effort will be made to contact me in case of medical emergency, I hereby give my permission to the physician selected by the University to hospitalize, secure proper treatment for, and order injections, anesthesia, or surgery for my daughter/son submitting this medical report.

Parent/guardian signature \_\_\_\_\_ Date \_\_\_\_\_

Printed name of parent/guardian \_\_\_\_\_ Phone \_\_\_\_\_

Address street \_\_\_\_\_ city \_\_\_\_\_ state \_\_\_\_\_ zip \_\_\_\_\_

### **Emergency Contacts**

Primary Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address Street \_\_\_\_\_ city \_\_\_\_\_ state \_\_\_\_\_ zip \_\_\_\_\_

Phone home \_\_\_\_\_ office \_\_\_\_\_ cell \_\_\_\_\_

Secondary Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address Street \_\_\_\_\_ city \_\_\_\_\_ state \_\_\_\_\_ zip \_\_\_\_\_

Phone home \_\_\_\_\_ office \_\_\_\_\_ cell \_\_\_\_\_

**Family History**

Are you adopted? Yes No

Name	Occupation	Year of Birth	State of Health	Age of Death	Cause of Death
Father					
Stepfather					
Mother					
Stepmother					
Sibling					
Sibling					

Please circle any of the following that have been experienced by close relatives: high blood pressure, heart disease, stroke, bleeding disorder, diabetes, ulcers, kidney disease, epilepsy, migraine, arthritis, cancer, tuberculosis, asthma, allergies, mental illness

**Part II: Immunizations**

Current immunizations for Tetnus/Diphtheria, Polio, Measles, Mumps, and Rubella are required for all TLU students. Vaccination against Hepatitis B and Meningococcal meningitis are recommended.

Hepatitis B – A blood-borne virus, considered to be a sexually transmitted disease. It can cause inflammation of the liver, tiredness, nausea, vomiting, liver cancer and liver failure. The vaccination is given in a three-dose series over a six-month period.

Meningococcal meningitis – A potentially life-threatening bacterial infection with early symptoms that mimic the flu. The meningococcal disease has been occurring more frequently since the early 1990's, especially among young adults in school and community settings. Reports from the CDC (Center for Disease Control) show freshmen living in residence halls have a six-times higher risk than college students overall. A safe and effective vaccine is available.

**Immunization Date** (Include month/day/year)

Tetanus/Diphtheria: Booster within past 10 years \_\_\_\_/\_\_\_\_/\_\_\_\_ Meningitis shot \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Polio: last date if under 18 \_\_\_\_/\_\_\_\_/\_\_\_\_

**Measles, Mumps, Rubella: if born after Jan. 1, 1957**

MMR Date 1: \_\_\_\_/\_\_\_\_/\_\_\_\_ OR Measles Date 1: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 MMR Date 2: \_\_\_\_/\_\_\_\_/\_\_\_\_ Measles Date 2: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Mumps \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Rubella \_\_\_\_/\_\_\_\_/\_\_\_\_

**Hepatitis B:**

Shot 1: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Shot 2: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Shot 3: \_\_\_\_/\_\_\_\_/\_\_\_\_

Last TB Test: Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Pos \_\_\_\_ Neg \_\_\_\_ If positive, chest X-ray \_\_\_\_/\_\_\_\_/\_\_\_\_

Current Medications \_\_\_\_\_

## Medical History

1. Describe any ongoing health problems or conditions requiring medical care.

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Please provide details: identify questions by number; include diagnosis, age or dates, and treatment.

<i>Have you ever had any of the following:</i>	<i>Yes</i>	<i>No</i>
2. Operation or serious injury		
3. Hospitalization		
4. Mumps		
5. Mononucleosis (Mono)		
6. German measles (Rubella)		
7. Hard/red measles (Rubeola)		
8. Chicken Pox		
9. Tuberculosis		
10. BCG Vaccine (TB vaccine)		
11. Adverse or allergic reaction to any medication		
12. Allergic reaction to food, insect bites, or other stimulus not related to medication		
13. X-ray therapy to the head or neck		

<i>Have you ever had or been treated for the following:</i>	<i>Yes</i>	<i>No</i>
14. Serious disease of eyes, ears, nose, or throat.		
15. Frequent or severe headaches or convulsions or severe head injury		
16. Lung disease, asthma, persistent cough, or shortness of breath		
17. High blood pressure, rheumatic fever, heart murmur, heart attack, or other disorder of heart or blood vessels		
19. Frequent or severe abdominal pain, hepatitis, problems with bowel movements, rectal bleeding. Or other intestinal problem		
19. sugar, protein, or blood in urine, or bladder or kidney problem		
20. A sexually transmitted disease (STD)		
21. Diabetes, thyroid, or other endocrine disorder		
22. Anemia or other disorder of the blood		
23. Bone, joint, or muscle problem; back pain; arthritis; physical deformity; or paralysis		
24. Hay fever, asthma, hives, or other allergy		
25. Severe acne, eczema, or other skin disorder		
26. Cancer or other tumor		
27. A disorder not listed above (specify)		

Do you know your blood type? Type: \_\_\_\_\_

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**Part III: Mental Health History** *This page must be completed by the student*

All information disclosed on this form will be kept confidential and will be shared with appropriate University personnel only on a need-to-know basis. Please return your completed form to the Division of Student Life & Learning, using the enclosed envelope.

**Student Information**

Name last \_\_\_\_\_ first \_\_\_\_\_ m.i. \_\_\_\_\_

Describe any medical or mental health problems or conditions that have required psychological care.

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please provide details: identify questions by number; include diagnosis, age or dates, and treatment.

<i>Have you had or experienced any of the following during the past four years?</i>	<u>Yes</u>	<u>No</u>
1. Depression		
2. An anxiety disorder		
3. An eating disorder		
4. Bipolar disorder		
5. Obsessive-compulsive disorder		
6. An anger management disorder		
7. Post traumatic stress disorder (PSTD)		
8. ADD/ADHD		
9. A suicide attempt		
10. Suicidal ideation		
11. A sleep disorder		
12. Panic disorder		
13. An anti-social or conduct disorder		
14. Alcohol or substance abuse or dependence		
15. Are you now taking or have ever taken medication for any of the above?		
(specify medication and dates) _____		
_____		
_____		

Please provide details: include diagnosis, age or dates, and treatment.

	<u>Yes</u>	<u>No</u>
Do you intend to begin or continue psychotherapy during college?		
Have you been hospitalized for a psychiatric disorder?		
Have you been treated for alcohol and/or drug addiction? (specify dates)		

### Part IV: Disability Inquiry.

Texas Lutheran University provides reasonable accommodations for students with documented physical/medical, learning, and or psychological disabilities and are initiated in the Office of the TLU ADA Coordinator located in the Meadows Center in the Alumni Student Center. Accommodations are available upon request to those students entitled to them under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990.

If you have a disability, please answer the following questions so that we will have an idea of the services you may need. By filling out and returning this form, you will be sent a copy of the University's policy for students with disabilities which will outline the required documentation, process of requesting documentation, and other pertinent information. For more information, please check our Web site at [www.tlu.edu](http://www.tlu.edu). *(Please note that filling out this form does not automatically qualify you for accommodations.)*

### Student Information

1. What is the nature of your disability?

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2. How and when was your disability diagnosed and documented?

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3. What types of accommodations have you used?

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4. What accommodations are you requesting at Texas Lutheran?

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5. Are there any new accommodations you anticipate requesting? If so, please specify.

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