UNIVERSITY OF DALLAS

Student Health Services Center

Welcome to University of Dallas! The following Health Form is both required and time-sensitive. Failure to complete the required information will impact your ability to attend class and move into your residence hall.

All 5 pages of the UD Health Form must be returned by July 1, 2025. For students confirming after July 1, Health Forms will be processed on a rolling basis as they are submitted. See page descriptions below. **TAKE ALL 5 PAGES to your physical exam appointment**. We highly recommend that you **keep a copy for your records**

PERSONAL AND FAMILY HISTORY - Page 1 of 5

Personal and Family History: Please complete all sections. This page **must be signed by both a parent/legal guardian and the student** and reviewed by your provider at your physical exam.

PHYSICAL EXAMINATION - Page 2 of 5

Physical Exam: A licensed Physician, Nurse Practitioner or Physician's Assistant **must complete and sign** the Physical Exam page and review the other pages of the Health Form. The examining physician may **NOT** be a family member.

IMMUNIZATION RECORD - Page 3 of 5

Immunization Record: Please fill out both the 'Required' and 'Recommended' sections **completely** and have the page **signed by a medical provider**. Option - A copy of other school records of your immunizations will suffice, *providing* it meets all of our requirements and your doctor signs the Immunization page as confirmation of your records. Failure to complete immunizations will impact your ability to register for classes and to move on campus.
******Urgent vaccine **EXEMPTION** information is located at the top of the Immunization Record page.******

EMERGENCY INFORMATION AND AUTHORIZATION SIGNATURE - Page 4 of 5

Emergency Information: All areas must be completed. If the student is less than 18 years of age, the page must be signed by a parent/legal guardian. If the student is covered under an insurance plan, please include a photo copy (front and back) of your insurance card with this page.

Page 5 of the form requires your health insurance information for medical care billing purposes.

PATIENT DEMOGRAPHICS - Page 5 of 5

Include a copy of the front and back of your current insurance card. (*This CANNOT be used to waive the student insurance program. See UD insurance waiver instructions here.)*
If the student is covered under an insurance plan, please include a photo copy (front and back) of your insurance card with this page. The student must also sign at the bottom of this page.

Form Return Methods (Keep a copy for your own records.)

Mail: University of Dallas
Student Health Services Center
1845 E. Northgate Drive
Irving, Texas 75062

Email: Scan to PDF and email to udhealthclinic@udallas.edu

Fax: 972-721-5124

Medical Insurance Waiver – for your information

All new incoming full-time undergraduates (except domestic seminarians) are automatically enrolled in and charged for the student insurance program. However, the university health insurance coverage may be waived upon proper submission of an online waiver directly with the insurance company broker. September 15, 2025 is the deadline date for online waiver submissions. This is a process that must be completed each academic year.

The online waiver form will be available about May 1, 2025. An email will also be sent to your UD email address once the waiver page is activated and will include instructions on how to submit the online waiver.

UNIVERSITY OF DALLAS

Personal & Family History

Page 1 of 5:
University of Dallas Health Form

ALL new students are **REQUIRED** to complete each page. Do not postpone your submission. **Registration will NOT be complete without all pages of this form.**

For the term beginning:

☐ Fall of 20_____ ☐ Spring of 20_____

STUDENT INFORMATION

To the student: This information will not affect your scholastic status. It will be used, if necessary, as an aid to provide health care while you are a student and as proof of immunization for the state of Texas. **This information is strictly for the use of the Student Health Services Center and will not be released to anyone without your knowledge and consent.**

Last Name	First Name	Sex	Date of Birth
Email Address	Cell Number		Home Number
Street Address			Apt. Number
City	State	Zip Code	
UD Student ID#	(If non-US citizen, please specify citizenship)		

FAMILY HISTORY

	Age	State of Health	Occupation	Age at Death	Cause of Death	List any relatives who have had:	
Father						Allergies/Hay Fever:	
Mother						Anxiety/Depression:	
Brothers						Asthma:	
						Cancer (type):	
						Diabetes:	
Sisters						Epilepsy:	
						High Blood Pressure:	
						High Cholesterol:	

PERSONAL HISTORY

Please check if you have had any of the following (include details and dates below).

Yes		Yes		Yes		Yes	
	Allergies to Medication		Heart Problems		Anxiety		Tumor, Cancer
			High Blood Pressure		Depression		Surgery:
	Chicken Pox		Sickle Cell Disease/Trait		Dizziness/Fainting		Date?
	Mononucleosis				Headaches, Recurrent		
	Malaria		Stomach/Intestinal Problems		Weakness/Paralysis		Females only:
	Tuberculosis		Gallbladder Disease		Worry/Nervousness		Irregular Periods
			Gum/Tooth Trouble				Severe Cramps
	Allergy/Hay Fever		Weight Loss/Gain		ADD/ADHD		Excessive Flow
	Asthma				Learning Difficulties		
	Ear, Nose, Throat Problems		Back Problems				Other:
	Eye Problems		Joint disease/Injury				

Have you ever had illness or injury other than noted above?

___Yes ___No Give details →

Have you been treated by a psychiatrist, psychologist or other mental health practitioner?

___Yes ___No

Have you ever been hospitalized for any physical or emotional disorder?

___Yes ___No Give details →

Do you have any *serious* dietary problems?
___Yes ___No Give details →

REMARKS OR ADDITIONAL INFORMATION
If you answered "YES" to any question on this page please explain below:
(Use additional sheet if necessary).

PARENT Signature (acknowledging review if student under 25) **Date**

STUDENT Signature (required) **Date**

Physical Exam

Page 2 of 5: University of Dallas Health Form

{EXAMINING PROVIDER MAY NOT be a family member**}**:

Please review the student's history (pg1), immunizations (pg 3), and medications (pg 4) and complete the Physical Exam signing at the bottom. Please comment on all positive answers. The information supplied will not affect the student's status. It will be used only as a background for providing health care.

This information is strictly for the use of the Student Health Services Center and will not be released without student consent.

Student's Last Name | **First Name** | M.I. | Sex

BP | Pulse | Height | Weight

R20/ L20/ Uncorrected Vision

R20/ L20/ Corrected Vision

[ ] Yes [ ] No Contacts

Medications, including allergy injections: (review page 4)

Drug/Latex allergies:

Current medical or emotional condition? (review pages 1&4)

Significant past physical or emotional problems? (review page 1)

Please check the appropriate column:	**Normal**	**Abnormal**	**Comments**
Head, face, scalp			
Neck, thyroid, lymph nodes			
Eyes, ears, nose			
Mouth and throat			
Lungs and chest			
Breasts			
Heart			
Abdomen			
Back			
Extremities and feet			
Neurological (reflexes, motor)			

RECOMMENDATION FOR PHYSICAL ACTIVITY (i.e., Intramurals, INTERCOLLEGIATE ATHLETICS)

☐ Unlimited ☐ Limited ☐ No Participation

Explain:

History of Sickle Cell Trait or Disease? ☐ Yes ☐ No

Is there any reason why this student should NOT live in a University residence hall? [ ] No [ ] Yes

Please explain:

Printed Physician's Name *(may NOT be a family member)* | **PHYSICIAN'S SIGNATURE** | Date

Address | Telephone Number

City | State | Zip Code

Immunization Record - Page 3 of 5: University of Dallas Health Form

These guidelines follow those outlined by the American College Health Association (ACHA) for "Institutional Prematriculation Immunizations" and the Texas Department of State Health Services. Required immunizations should be completed **PRIOR** to registration. Recommended vaccines are not required, but encouraged.
Please fill out the form as **COMPLETELY** as possible.

EXEMPTIONS: Students seeking an exemption from vaccines **REQUIRED** by the state of Texas **must** *immediately* request an exemption form from the Texas Department of State Health Services. **Only the state original** may be sent to the UD Student Health Center BEFORE the submission deadline. An exemption affidavit from the State of Texas is available at **https://co-request.dshs.texas.gov/** This is not an instantaneous process, so do NOT delay and miss the deadline. Non-Texans: Do NOT sign the form as it **MUST** be signed by a **Texas** notary. Additional questions may be sent to the UD Student Health Center at udhealthclinic@udallas.edu or via call to 972.721.5322

Last Name	First Name	MI	DOB

REQUIRED Vaccines		***Enter complete date (mo/day/yr)***		
Meningococcal (if < 22 yrs old)	MCV-4 (A,C,W,Y)	1.	2.	*(last dose within 5 years)*
Tetanus booster	Td/Tdap **(circle)**	1.		*(last dose within 10 years)*

RECOMMENDED Vaccines		***Enter complete date (mo/day/yr)***				
Chickenpox	Varicella	1.	2.	*or date of titer:*	*or date of disease:*	
Hepatitis A	Hep A or Hep A/B	1.	2.			
Hepatitis B	Hep B or Hep A/B	1.	2	3	*or date of titer:*	
Human Papilloma Virus	HPV 4- or 9-valent	1.	2.	3.		
Influenza	TIV/LAIV					
Measles/Mumps/Rubella	MMR	1.	2.			
Meningococcal serogroup B	Trumenba or Bexsero **(circle)**	1.	2.	3.		
Polio	OPV/IPV	1.	2.	3.		
Pneumococcal	PCV13 or PPSV23					
Other						
Covid-19 Vaccine Mfr:_____		1.	2.		*or date of disease:*	

Tuberculosis Screening *(only if student at risk)*

PPD or **Date:** **Result: _____mm** **Negative ( ) Positive ( )**

Quanti-FERON-TB **Date:** **Result: titer :** **Negative ( ) Positive ( )**

To the best of my knowledge, the person named above has received the immunizations listed on this form.

HEALTH CARE PROVIDER SIGNATURE

Printed Name	Signature	Date

Address	City/State	Zip code	Phone Number

Emergency Information

NAME: _____

Last **First** **Middle I.**

SS#: _____

Date of Birth: _____/_____/_____

Allergies (medicine, food, insects, etc.)_____

_____

Medical Conditions: (allergies, diabetes, heart disease, depression, anxiety, asthma, etc.)

1. _____ **4.** _____

2. _____ **5.** _____

3. _____ **6.** _____

Current Medications/Supplements:

1. _____ **For:** _____ **How long?**_____

2. _____ **For:** _____ **How long?**_____

3. _____ **For:** _____ **How long?**_____

4. _____ **For:** _____ **How long?**_____

5. _____ **For:** _____ **How long?**_____

6. _____ **For:** _____ **How long?**_____

Emergency Contact Information - In case of emergency, contact:

Family Member: _____

Relationship: _____

Home Phone: (_____) _____

Cell Phone: (_____)_____

Work Phone: (_____)_____

PARENT/GUARDIAN MEDICAL RELEASE (*Must be completed for students under 18 years of age.)*

I give permission for diagnostic, therapeutic, and/or operative procedures, should an emergency arise. In such an instance, the University of Dallas, through its physician or other medical authority, may act with my approval in treating my son/daughter/ward.

Signature: _____ **Date:** _____

PATIENT DEMOGRAPHICS

Patient Name (Last, First, Middle Initial)	Gender	Date of Birth	Univ of Dallas ID#
Home Address	City State Zip		Phone # ◯ cell ◯ home
Email Address			
Emergency Contact Name	Relationship		Phone # ◯ cell ◯ home

Note: Full disclosure is important for proper care in case of emergency. All information is kept confidential

PRIMARY INSURANCE - Please attach **front and back** copy of insurance card

Insurance Name	Primary Subscriber_____DOB_____ Subscriber SSN_____
Insurance Address City State Zip Phone #	
Insurance Member ID (or Certificate) #	Group (or Policy) #

Relationship of Patient to Insured: ◯ Dependent ◯ Self ◯ Spouse ◯ Other

Do you have a SECONDARY INSURANCE? ◯ **Yes** ◯ **No** **If so, fill in the following:**

Insurance Name/ Name of Primary Subscriber/ Member ID#/ Group #

Do you have Medicare or Medicaid? ◯ **Yes** ◯ **No** **Medicare/Medicaid No.**

CONSENT FOR TREATMENT, PRIVACY NOTIFICATION AND INSURANCE BILLING

Please check each box and sign below:

☐ 1. I understand that the mission of the University of Dallas Student Health Center is to provide preventive medical care; including immunizations and physical exams; to diagnose and treat acute illness and minor emergencies; to help with management of chronic medical conditions; to provide support for mental health concerns; and to provide referrals to specialists as needed. I consent to have the physician on staff treat me for the above conditions.

☐ 2. I acknowledge that I have received and read a copy of the NOTICE OF PRIVACY PRACTICES and understand that my medical information will be kept private except in circumstances as outlined in the notice.

I prefer to be contacted in the following manner (select all that apply): ☐ phone ☐ email ☐ other _____

The following people may have access to my medical information:

Name _____ Relationship to patient ◯ Parent ◯ Spouse ◯ Friend ◯ Other _____

Name _____ Relationship to patient ◯ Parent ◯ Spouse ◯ Friend ◯ Other _____

☐ 3. I hereby authorize the University of Dallas Student Health Center to furnish information to my insurance carrier(s) concerning my illness, condition and treatment, and I hereby irrevocably assign to The University of Dallas Student Health Center all payments made by my insurance carrier(s) for services rendered. I understand that I will pay all charges, co-pays, deductibles, and coinsurance not covered by my insurance carrier(s) and understand that these charges may be placed on my student account.

☐ 4. The University Student Health Center offers the opportunity for pre-health students to serve as clinic assistants, either as student workers or as interns. I will alert the staff if I prefer *not* to have a student present during my visit.

STUDENT SIGNATURE **DATE**