

# O·B·U Student Health Service Record

**Do Not Write in This Area**  
Received \_\_\_\_\_  
Notice Sent \_\_\_\_\_  
Completed \_\_\_\_\_  
Adm. Notified \_\_\_\_\_

**NEW STUDENTS:** This form must be completed prior to enrollment. The personal history below should be completed and signed by the student *before* having the physical exam. Please attach a copy of your immunization records to the form.

**TRANSFER STUDENTS:** A copy of your health record from your previous institution will be accepted, but must include a copy of your immunization record.

The information you provide is confidential and is protected by law. It will be used only by the Student Health Services and Student Development staff to aid in providing necessary health care while you are a student.

## To be completed by the student:

Social Security # \_\_\_\_\_ OBU I.D.# \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Sex: Male\_\_\_ Female\_\_\_

Date of Planned Enrollment at OBU: Fall \_\_\_\_\_ Spring \_\_\_\_\_ J-Term \_\_\_\_\_ Summer \_\_\_\_\_ Year \_\_\_\_\_

Name \_\_\_\_\_ Email \_\_\_\_\_  
Last First Middle

Home Address \_\_\_\_\_  
P.O. Box or Street City State Zip

## MEDICAL HISTORY:

HISTORY OF DISEASES (please check diseases you have had and give approximate age)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Measles         | <input type="checkbox"/> Typhoid       | <input type="checkbox"/> Epilepsy      |
| <input type="checkbox"/> German Measles  | <input type="checkbox"/> Malaria       | <input type="checkbox"/> Hepatitis     |
| <input type="checkbox"/> Mumps           | <input type="checkbox"/> Gastric Ulcer | <input type="checkbox"/> Diphtheria    |
| <input type="checkbox"/> Chicken Pox     | <input type="checkbox"/> Asthma        | <input type="checkbox"/> Arthritis     |
| <input type="checkbox"/> Whooping Cough  | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Tonsilitis    |
| <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Sinusitis     | <input type="checkbox"/> Pneumonia     |
| <input type="checkbox"/> Bronchitis      | <input type="checkbox"/> Poliomyelitis |  |

## HISTORY OF OPERATIONS AND INJURIES:

Specify operations, giving nature and dates \_\_\_\_\_  
\_\_\_\_\_

## PERSONAL HISTORY:

Do you have a physical restriction or handicap? If yes, explain \_\_\_\_\_

Have you ever been under treatment for a mental or emotional illness or depression?  Yes  No

Have you ever been treated for drug or alcohol abuse?  Yes  No

Type of Treatment \_\_\_\_\_

List of medication that you are presently taking \_\_\_\_\_

List of any known drug allergies \_\_\_\_\_

Has any blood relative had the following diseases? State relationship to you.

- |                                       |                                     |  |
|---------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Asthma     | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Hemophilia |  |

Have you ever had the following?

- |  |   |                                      |
|--|---|--------------------------------------|
| <input type="checkbox"/> Fainting or Dizziness     | <input type="checkbox"/> Persistent Cough           | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Frequent/Severe Headaches | <input type="checkbox"/> Back Trouble               | <input type="checkbox"/> Hay Fever   |
| <input type="checkbox"/> Swollen or Painful Joints | <input type="checkbox"/> Stomach/Intestinal Trouble |                                      |

I certify that the above history is complete to the best of my knowledge \_\_\_\_\_  
Signature of Student

## AUTHORIZATION FOR MEDICAL TREATMENT:

Permission is hereby granted to any duly licensed physician and OBU Health Service to perform emergency treatment and to refer the student to another duly licensed physician, surgeon or dentist for necessary treatment when indicated.

\_\_\_\_\_  
Signature of Parent or Guardian if applicant is a minor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

**EMERGENCY NOTIFICATION DATA:** Parent, Guardian or next of kin \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Second Name (Friend or Relative) \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

(over)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ OBU I.D.# \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

**To be completed by physician, physician's assistant, or nurse practitioner:**

**PHYSICAL EXAMINATION:**

HEIGHT _____	WEIGHT _____	BLOOD PRESSURE _____	PULSE _____
EYES: VISION R _____ L _____	SKIN _____	GUMS _____	
CORRECTED R _____ L _____	NOSE _____	THYROID _____	
EARS: TYRANUM R _____ L _____	THROAT _____	LYMPH GLANDS _____	
HEARING R _____ L _____	TONSILS _____	TEETH _____	
ANY EVIDENCE OF HEARING LOSS? <input type="checkbox"/> Yes <input type="checkbox"/> No	ABDOMEN AND VISCERA _____	CHEST: _____	
MAMMAE _____	SPINE AND OTHER MUSCULOSKELETAL _____		
LUNGS _____	EXTREMITIES _____		
HEART (RHYTHM, MURMUR) _____	NEUROLOGIC _____		

**LABORATORY IF INDICATED:**

URINALYSIS: SP. GR. \_\_\_\_\_ ALB. \_\_\_\_\_ SUGAR \_\_\_\_\_ MICRO. \_\_\_\_\_

HEMOGLOBIN \_\_\_\_\_

CHEST X-RAY \_\_\_\_\_ DATE \_\_\_\_\_ RESULT \_\_\_\_\_

**IMMUNIZATIONS (Guidelines follow DODC Recommendations).**

**PLEASE ATTACH A COPY OF IMMUNIZATION RECORD. (MUST BE IN ENGLISH).**

TUBERCULOSIS SCREENING (Required within the past one year) or BCG Date \_\_\_\_\_

1. PPD date read: \_\_\_\_\_ RESULTS \_\_\_\_\_ mm
2. If PPD is positive (10mm or greater) chest X-Ray required. X-Ray results: Normal \_\_\_\_\_ Abnormal \_\_\_\_\_
3. If treated for TB, please submit copy of medical record indicating treatment (**MUST BE IN ENGLISH**).

DIPHTHERIA/PERTUSSIS/TETANUS INITIAL SERIES DATES (5) \_\_\_\_\_

TETANUS BOOSTER (Required every 10 years) DATE \_\_\_\_\_

POLIO: INITIAL SERIES DATES (4) \_\_\_\_\_

POLIO BOOSTER DATE \_\_\_\_\_

MEASLES/MUMPS/RUBELLA (Required by state law) DOSE 1 DATE \_\_\_\_\_

MMR BOOSTER (Required by state law) DOSE 2 DATE \_\_\_\_\_

VARICELLA (Chicken Pox) or Date of Disease DOSE 1 DATE \_\_\_\_\_ DOSE 2 DATE \_\_\_\_\_

MENINGOCOCCAL VACCINE DATE \_\_\_\_\_ (Required of all first-time enrollees who are residing in on-campus housing)

HEPATITIS B (Required by state law) DOSE 1 DATE \_\_\_\_\_ DOSE 2 DATE \_\_\_\_\_ DOSE 3 DATE \_\_\_\_\_

HEPATITIS A (Strongly Recommended) DOSE 1 DATE \_\_\_\_\_ DOSE 2 DATE \_\_\_\_\_

**TO THE EXAMINING PHYSICIAN:**

Do you feel that this student will be able to participate in vigorous physical activity (of an aerobic nature)?  Yes  No

If not, please give information which would help us in adapting our fitness program to fit this student's needs, such as the limiting condition(s), restrictions to be placed on physical activity, etc.

Would it be possible to work with you and/or the local physicians associated with our program in prescribing exercise for this individual?

Please add any additional information you may think necessary to the Medical History.

Optional laboratory tests should be done if you feel they are indicated.

REMARKS BY EXAMINING PHYSICIAN: \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature Date

**Note: OBU does not carry health and accident insurance on OBU students. You are urged to carry adequate health and accident insurance.**

INSURANCE PLAN \_\_\_\_\_

AGREEMENT NUMBER \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_