STUDENT HEALTH RECORD

(All new students must complete all three pages of the form. Failure to comply will result in a hold being placed on future enrollment)

OKLAHOMA BAPTIST UNIVERSITY

NAME _____ Male ☐ Female ☐
(Last) (First) (Middle)

OBU ID # _____ Date of Birth _____/ _____/ _____ Cell Phone _____ Email _____

Please write year and circle semester you plan to start: Fall ____ Spring ____ J-Term ____

Home Address _____
PO Box / Street City State Zip

EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____ Phone: _____

Name _____ Relationship _____ Phone: _____

MEDICAL HISTORY-Have you ever had any of the following? (check all that apply)

___ Alcohol Abuse	___ Anemia	___ Arthritis	___ Asthma
___ Back Problems	___ Chronic Cough	___ Cancer	___Colitis
___ Convulsions/Seizures	___ Depression	___ Diabetes	___Disability
___ Drug Abuse	___ Eating Disorder	___ Chronic Hayfever	___ Hepatitis
___ Headache Chronic/Migraine	___ Heart Disease	___ Head Injury	___ Hernia
___ High Blood Pressure	___ High Cholesterol	___ Heart Murmur	___Hemophilia
___ Intestinal/Stomach Disorders	___ Malaria	___ Kidney Disease	___ Mono
___ Menstrual Problems/Pain	___ Orthopedic Problems	___ Pneumonia	___ Polio
___ Psychological Counseling	___ Sickle Cell Disease	___ Rheumatic Fever	___ Mumps
___ Loss of Consciousness/Fainting	___ Sleep Disorder	___ Stroke	___ TB
___ Positive TB Skin Tests	___ Thyroid Disease	___ Spleen Removed	___ Measles
___ Chronic Sinus Infections	___ Chicken Pox	___ Chronic Bladder/Urinary Infections	

Brief Explanation of any **CHECKED** responses: _____

History of Surgery: specify operations, giving nature, dates and any complications: _____

List of Current Medications:
_____
_____
_____
_____
_____

Medication Allergies: YES NO
(List Medication/Reaction) _____
_____
_____

Have you been treated for drug or alcohol abuse? YES NO
Type of Treatment: _____

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 of student as a minor **Signature of Student** **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 _____

ID NUMBER _____ GROUP NUMBER _____

ALL INFORMATION PROVIDED IS CONFIDENTIAL

Return this form to: Student Health Services | OBU Box 61806 | 500 W. University | Shawnee, OK 74804
Questions? Call Student Health Services, 405.585.5263 | fax: 405.585.5266 | Monday-Friday, 8am-5pm | email: health@okbu.edu

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

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

Source: World Health Organization Global Health Observatory, 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) The significance of the travel exposure should be discussed with your doctor. Yes ❑ No

Have you been a resident 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, Oklahoma Baptist University requires that you receive TB testing as soon as possible but at least prior to the start of classes. See TB skin test on page 3.

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

Signature: _____ *Date:* _____.

Name _____ OBU ID #_____

Immunization Record

TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER
(Copies of Shot Records **MUST BE IN ENGLISH**)

Required Vaccinations

Vaccine Enter date each immunization was given

Measles, Mumps Rubella (Month, Day, Year)	#1	#2	
Hepatitis B (Month, Day, Year)	#1	#2	#3

Required for first time students living in campus housing (Required within past 5 years)

Meningococcal Quadrivalent polysaccharide vaccine	#1

Recommended Vaccinations

Tetanus-Diphtheria DTaP or DTP and booster with Td	#1	#2	#3	#4	#5	booster
Polio (OPV / IPV)	#1	#2	#3	booster		
Hepatitis A (Month, Day, Year)	#1	#2				
Varicella (Chicken Pox) (Or Date of Disease)	#1	#2				

TB skin test is required if you answered yes to any of the questions on page 2. For International Students, TB skin test must be done in the US.

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

To the best of my knowledge, the person above has received the above immunizations

Signed _____Title _____Date _____
(Physician, nurse or school authority – **Please be sure there are 2 MMR's and 3 Hep B's**)

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

PHYSICAL EXAMINATION:

HEIGHT_____ WEIGHT_____
EYES: VISION R_____ L_____
CORRECTED R_____ L_____
EARS: TYPANUM R_____ L_____
HEARING R_____ L_____
ANY EVIDENCE OF HEARING LOSS? ☐ YES ☐ NO
MAMMAE_____
LUNGS_____
HEART (RHYTHM, MURMUR)_____

BLOOD PRESSURE_____ PULSE_____
SKIN_____ GUMS _____
NOSE_____ THYROID_____
THROAT_____ LYMPH GLANDS_____
TONSILS_____ TEETH_____
ABDOMEN AND VISCERA_____CHEST_____
SPINE AND OTHER MUSCULOSKELETAL_____
EXTREMITIES_____
NEUROLOGIC_____

LABORATORY IF INDICATED:

URINALYSIS: SP. GR._____ ALB._____ SUGAR_____MICRO. _____
HEMOGLOBIN _____ CHEST X-RAY _____
DATE_____ **RESULT** _____

TO THE EXAMINING PHYSICIAN:

Do you feel that this student will be able to participate in vigorous physical activity (or 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.
REMARKS BY EXAMINING PHYSICIAN:_____

_____ _____
Physician's Signature **Date**