STUDENT HEALTH RECORD

(All new students must complete both sides of 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 _____

AGREEMENT 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

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				

Required Tuberculosis Screening (Required within the past year)

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**