Arlington
Baptist
University

For Term Beginning

Fall______________

Spring ____________

Student Health Information

Enrollment, Intercollegiate Athletes

The information on this form is important to the entering student's college health record. Pages 1 and 2 should be filled out by the student with the help of his/her parents. Pages 3 and 4 should be completed by the family physician during and after the required physical exam and immunizations. Send the entire completed form to: Arlington Baptist University, Admissions Office, 3001 West Division Street, Arlington, TX 76012.

Today's Date______/______/________ (Month Day Year)   Gender ☐Male ☐Female   Student's Date of Birth _______/_______/________ (Month Day Year)

Student's Full Name____ SSN_____________________
Home Address____ Home Phone ( )__________________
City______________________________State______Zip__________ Student Cell ( ) ______________________
Sport(s) of Participation____
Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

PARENT INFORMATION (Custodial Parent/Step-Parent/Guardian)

Father/Guardian's Name____________________________
Address____
City____
State__________Zip_______________________________
Employer____
Employer Phone ( )_____________________________

Mother's/Guardian's Name________________________
Address____
City____
State____________Zip_____________________________
Employer____
Employer Phone ( )_____________________________

SPOUSE INFORMATION (For married commuter students)

Spouse Name____
Employer____Employer Phone ( ) ____________________________

In Case parents/spouse are unable to be notified in the event of an emergency, we need another contact person.
Contact other than parents/spouse____
Relationship_______________________________________ Phone Number(s)_____________________________

Family Physician___________________________________ Phone ( ) _________________________________
Address____

TO BE FILLED OUT BY STUDENT OR PARENT/GUARDIAN

Current Medications

Drug Name	Dose and Frequency	Reason

Allergies (Medications, Foods, environmental)

Allergic To	Reaction	Treatment

Medical History

	Yes	**No**			**Yes**	**No**
Anemia or other Blood Diseases				Stomach/Intestinal		
Concussion				Cancer		
Hepatitis				Bone/Joint Deformity		
Missing/Non Functional internal Organs				Eye Disease		
Meningitis				Mononucleosis		
Rupture/Hernia				Kidney Problems		
Rheumatic Fever						

Please explain all YES answers. Attach a separate sheet if necessary. ___________________________________
____

Medical Illness or Problems

Heart Disease (hypertension, etc.)____
Endocrine problem (thyroid, diabetes, etc.)____
Epilepsy (seizure disorder)____
Pulmonary problem (bronchitis, asthma, pneumonia, etc.)____
Other____

Mental Health Care (Psychiatric or Psychological)

Eating disorder (anorexia, bulimia)____
Depression/Anxiety/Bipolor disorder, etc.____
Suicide Attempts____
Alcohol/Drug treatment: Dates of treatment____
Outpatient care: Diagnois, Dates of treatment, Medications____
Inpatient care: Diagnosis, Dates of treatment, Medications____

Previous Hospitalizations/Operations

Date	Reason

I certify that all the above information is complete and accurate to the best of my knowledge.

Signature of Student____ Date_______________________

TO BE FILLED OUT BY PHYSICIAN

MANDATORY FOR ENROLLMENT

	Month Day Year
TETANUS-DIPTHERIA (REQUIRED)	
1. Completed primary series of tetanus-diphtheria immunizations	________________________________
2. Received tetanus-diphtheria booster within last 10 years	________________________________
M.M.R. MEASLES, MUMPS, RUBELLA (REQUIRED)	
1. Dose 1-immunized on or after 12 months of age	________________________________
2. Dose 2-immunized after 1987	________________________________
Provide proof of confirmed disease	
TUBERCULOSIS (REQUIRED)	
1. TB test within the past year (Date Given)	________________________________
Results____________________________ (Date Read)	________________________________
2. Positive TB test. Chest x-ray required	
Give date and results of chest x-ray	________________________________
VARICELLA – CHICKEN POX (REQUIRED)	
(Immunity verified by one of the following :)	
1. Personal history of Varicella (list date)	________________________________
2. Health care provider diagnosed Varicella (list date)	________________________________
3. Two injections of Varicella vaccine (list dates)	________________________________
POLIO (REQUIRED)	
1. Adequate primary series of polio (if immunization status cannot be documented, primary series must be started with written agreement to complete the series according to schedule.)	________________________________
HEPATITIS B (REQUIRED)	
1. Adequate series of hepatitis B (specify dates)	________________________________
MENINGOCOCCAL MENINGITIS (REQUIRED UNDER THE AGE OF 22)	
1. Vaccination ☐Yes ☐No (If yes, provide date)	________________________________

TO BE FILLED OUT BY PHYSICIAN

MANDATORY FOR ENROLLMENT

Patient's Full Name____
Birthdate______________________________Weight___________Height______________________
Blood Pressure __________/______________ Pulse___________ Respiration__________________

Please Give Details of Any Abnormal Findings
Head______________________________________ Neck__________________________________
Skin_______________________________________ Eyes__________________________________
EENT____
Chest_____________________________________ Heart_________________________________
Abdomen__________________________________ Extremities____________________________
List Any Additional Comments____

Are you aware of any medical or psychological problems which might affect this student's ability to carry a full load of academic studies? ☐Yes ☐No If yes, please document the nature and the extent of the limitation.

Are you aware of any medical or psychological problems which might affect this student's ability to participate in any physical activities or social events? ☐Yes ☐No If yes, please document the nature and the extent of the limitation.

Release for full participation? ☐Yes ☐No

By signing below, I acknowledge that the information of this document is accurate and complete.

Physician's Name____________________________ Signature____
Address____ Phone ( )____________________________
City_________________________________ State_________ Zip___________________

Date____________________________

Please note: The information you provide on this form is strictly for the use of the Student Services Office and Athletic Department and will not be released to anyone without your knowledge and consent.