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. This form is kept in the student's file. The information on this form is necessary in the case of an emergency and will not hinder a student being admitted to ABU. The completed form can be sent 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_____

Phone ( )_____

Email Address_____

Employer_____

Mother's/Guardian's Name_____

Address_____

City_____

State_____Zip_____

Phone ( )_____

Email Address _____

Employer_____

SPOUSE INFORMATION (For married commuter students)

Spouse Name_____ Phone ( )_____

Email Address_____ Employer_____

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/Bipolar disorder, etc._____

Suicide Attempts_____

Alcohol/Drug treatment: Dates of treatment_____

Outpatient care: Diagnosis, 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_____