Ouachita Baptist University
Immunization Requirements

PLEASE READ CAREFULLY

Measles/Mumps/Rubella Requirements (MMR)
Ouachita Baptist University and the Arkansas Department of Health require that students born after December 31, 1956, have 2 doses of the MMR vaccine. The first dose of the MMR vaccine must be after your first birthday.

Meningitis Information
Arkansas Act 1233 of 1999 requires us to inform you of a bacterial infection known as meningitis. Although meningitis is rare, individuals who live in close proximity to many others, such as in residence halls, have a slightly higher risk of contracting this disease. There is a vaccine available and Ouachita Baptist University recommends that all students living in residence halls discuss receiving this vaccine with their Health Care Provider.

Tuberculosis (TB) Screening
TB Screening is required in OBU Health Services of all foreign-born students where TB is endemic.

* If you were born in Asia, Africa, Central or South America or Eastern Europe and are not a permanent resident of the United States or if you have had any contact with a person with known active TB you must come to Health Services for a TB skin test.
* A negative chest x-ray or a BCG vaccination is not a substitute for a skin test for International Students.
* TB skin test is required for any student that does not fit into the category as foreign-born, but has lived outside of the US in the last 12 months. It can be done prior to registration at your Healthcare provider.

Religious/Philosophical Exemptions: Only the Arkansas Department of Health provides this exemption. It must be renewed yearly. Forms can be obtained by e-mail only-immunization.section@arkansas.gov They may be contacted by calling 501-661-2169 for questions.

Medical Exemption: Must provide proof of immunity by serological testing, history of the disease, or medically contraindicated. Appropriate documentation must be sent to Health Services for approval.

Instructions: Immunization records may be submitted to the University in the following ways:

Copies of personal immunization records that have been signed by your physician
Copies of physician office or Health Department immunization records
Copies of records from another educational institution (college, high school)
Have the following form completed and signed by your Health Care Provider

*Immunization Records must be in prior to registration or your classes will be put on hold.
Ouachita Baptist University Immunization Form

Please submit all **Immunizations** and **Health Form** to:
Ouachita Baptist University
Office of the Registrar
PO Box 3757
Arkadelphia AR, 71998-001

Last Name_________________________First Name______________________MI____
Preferred Name__________________OBU ID________Date of Birth ___/____/_____
Country of Birth_______________Social Security No. __/_/- __/_/- __/_/- __/_/- __/_/- __/_/-
Student Status: Freshman_____Transfer_____Returning Student _____

**Immunizations Required by Arkansas Health Laws**

**MMR (Measles, Mumps, Rubella)**
1. MMR ____/____/_____  2. MMR ____/_____/_____  
   Mo.   Day   Year                                               Mo.   Day   Year

**Immunizations Recommended**

**TUBERCULOSIS SKIN TEST**
   ____/____/___ Results __________mm
   Mo. Day Year

*REQUIRED If you have lived out of the country in the last 12 months
*International students living in endemic areas to receive TB skin test in OBU Health Services

**MENINGOCOCCAL**

   ____/____/___  Mo. Day Year

**TD/Tdap (Booster within the last 10 years)**

   ____/____/____  Mo. Day Year

**HEPITITIS B (Three doses or TWINIX)**

1. ____/____/____  2. ____/____/____  3. ____/____/____
   Mo. Day Year       Mo. Day Year       Mo. Day Year

**HEPITITIS A**

1. ____/____/____  2. ____/____/____
   Mo. Day Year       Mo. Day Year

**HEALTH CARE PROVIDER**

Name/Title__________________________________Address___________________________________
Signature ____________________________________________Telephone (_____) _________________
OBU ID #_______
Ouachita Baptist University
Health Form

Student Information
Student’s Preferred Name________________________________________________
Parent(s), Guardian or Spouse____________________________________________
Home phone (       )______________________Work Phone (        )________________

Medical Insurance (You may attach a copy of your card to the form if preferred)
Company_______________________________________________________________
Policy Number __________________________Policy Holder____________________
Primary Care Physician___________________________________________________
Address _______________________________Telephone (        ) __________________

*The University provides information concerning a group policy for students who are not covered otherwise.

Student’s Medical History

Has the student ever had or now have any of the following? If yes, please give the date diagnosed and/or treated:

<table>
<thead>
<tr>
<th>Disease</th>
<th>Y/N</th>
<th>Date</th>
<th>Disease</th>
<th>Y/N</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>_____</td>
<td>____________</td>
<td>Epilepsy/Seizures</td>
<td>_____</td>
<td>____________</td>
</tr>
<tr>
<td>Surgery</td>
<td>_____</td>
<td>____________</td>
<td>Heart Disease</td>
<td>_____</td>
<td>____________</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>_____</td>
<td>____________</td>
<td>Kidney Disease</td>
<td>_____</td>
<td>____________</td>
</tr>
<tr>
<td>Chicken Pox</td>
<td>_____</td>
<td>____________</td>
<td>High Blood Pressure</td>
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</tr>
<tr>
<td>Asthma</td>
<td>______</td>
<td>____________</td>
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</tbody>
</table>

Any other significant diseases or illnesses:

Further comments on any of the above that were answered YES

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POLICY ON COMMUNICABLE DISEASES
Ouachita reserves the right to restrict campus activities or access to any student, prospective student, or campus visitor, who has been diagnosed as having a contagious or communicable disease or virus.

It is assumed that students are free of any communicable disease while a part of the university community. Any student who knows, or who has reason to believe, that he/she may be infected by a communicable disease must report this information to the university health service, who will then inform the Vice President for Student Services. Any restrictions and/or exclusions deemed necessary for the welfare of all students will be determined in light of the most current medical knowledge and in accordance with state and federal law.

List any medications taken regularly

List any known allergies to: Medication_________________________Food___________ Other _______

Is there any physical condition that prohibits participation in physical activity? Yes__________No__________

If yes, please explain______________________________________________________________

To the best of my knowledge, the above information is true and correct.

STUDENT/PARENT/GUARDIAN SIGNATURE _________________________ DATE __________