Immunization Request

ID/SOCIAL SECURITY #_____ DATE_____

I, _____, give my permission for OBU to release my medical records to the person(s) and/or institution(s) named below:
(name)

Mail or Fax to:

_____

_____

_____

STUDENT SIGNATURE: _____

Ouachita Baptist University - Registrar's Office - P.O. Box 3757
Arkadelphia, AR 71998-0001
Phone: 870-245-5578 Fax: 870-245-5194