

Ouachita Baptist University  
Health Form and Authorizations

Name \_\_\_\_\_ Preferred: \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Country of Birth \_\_\_\_\_  
Emergency Contact: Name \_\_\_\_\_ Phone: \_\_\_\_\_

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**Health Insurance Information:**

Ouachita Baptist University recommends that all students have medical insurance.

It is important to check your insurance carrier to see what physicians in the area take your particular insurance prior to coming to school. **Please bring a copy of your card with you.**

If you do not have any insurance, please be aware that you will be financially responsible for any Health issues, accidents or injuries you may have while at Ouachita that is not able to be taken care of in Health Services.

**Medical History**

Please include any current and past medical history (asthma, diabetes, seizures, depression, anxiety)

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**Current Medications:**

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**Allergies (medication, food, environmental)**

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Do you have an epi pen? \_\_\_yes \_\_\_no

**Mental Health:** have you ever been diagnosed or have had counseling for a Mental Health Illness? (anxiety, depression, ADHD, eating disorder)

Please explain: \_\_\_\_\_

Current medication: \_\_\_\_\_ Past Medication: \_\_\_\_\_

If you need to discuss any special services that you require, please contact the Campus Nurse via email [wallacem@obu.edu](mailto:wallacem@obu.edu) or 870245-5244

**Authorizations:**

I authorize Health Services to disclose Protected Health Information to the following. Please list all that apply

For example: name of parents, guardian, PCP, allergist, counselor, coach/athletic trainer (highly encouraged if you are an intercollegiate athlete)

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

This will be kept until the student either graduates or is no longer enrolled at Ouachita Baptist University.

By uploading this, I agree that all of the information above is true.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date