

Health Record

Entered: Fall Spring Year: _____

STUDENT INFORMATION

Name _____ DOB _____ / ____ / ____ SSN _____ - ____ - ____
LAST FIRST MIDDLE MM DD YYYY

Address: _____
STREET/ROAD/BOX# CITY STATE POSTAL CODE COUNTRY

Gender: Male Female Cell (____) _____ - _____ Email: _____

EMERGENCY CONTACT INFORMATION

Circle One: Parent Guardian Spouse Name: _____ Cell: (____) _____ - _____
LAST FIRST

Address: _____ Home: (____) _____ - _____
STREET/ROAD/BOX#

CITY STATE POSTAL CODE COUNTRY

IMMUNIZATION RECORD

Immunizations required for enrollment: must be completed & signed by health care professional or attach official copies with stamp or letterhead from your health care provider or high school. Attach medical or religious waiver complaint with the laws of NY/FL where applicable. *All immunization documentation must be in English language.*

Immunization Record: MMR and current tetanus are required. *If you have not had the Hepatitis B or Meningitis vaccinations you must complete the waiver below before signing the health form and submitting it.*

	MMR	Most recent Tetanus (Td/Tdap)	Meningitis	Hepatitis B
Dose 1				
Dose 2				
Dose 3				

Mantoux Tuberculosis Skin Test: TB skin test (and x-ray if test is positive) must be within 1yr of admission.

Date of last TB skin test: ____ / ____ / ____ Results: _____ mm induration. If positive provide chest x-ray documentation
MM DD YYYY
 Have you ever been treated for tuberculosis? Yes No Have you received the BCG vaccine? Yes ____ / ____ / ____ No
MM DD YYYY

Health Care Provider: Complete the above information, sign and date

PRINT NAME AND TITLE SIGNATURE DATE: MM DD YYYY

INSURANCE INFORMATION

Do you have Health Insurance? Yes No Name of provider: _____

ATTACH COPY OF INSURANCE CARDS

RESPONSE AND CONSENT

Check one statement regarding Meningococcal Meningitis if you have not had the vaccine:

- I have (my child has) read, or have had explained to me information regarding meningococcal meningitis disease. I (my child) will obtain immunization against meningococcal meningitis within 30 days of the first day of class from my private health care provider or Word of Life Bible Institute health center will facilitate the immunization via a local physician's office.
- I have (my child has) read, or have had explained to me information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I (my child) will not obtain immunization against meningococcal meningitis disease.

Check one statement regarding Hepatitis B if you have not had the vaccine:

- I have (my child has) read, or have had explained to me information regarding Hepatitis B disease. I (my child) will obtain immunization against Hepatitis B within 30 days of the first day of class from my private health care provider or Word of Life Bible Institute health center will facilitate the immunization via a local physician's office.
- I have (my child has) read, or have had explained to me information regarding Hepatitis B disease. I understand the risks of not receiving the vaccine. I have decided that I (my child) will not obtain immunization against Hepatitis B disease.

Read and sign:

I hereby authorize the Health Care Staff at Word of Life Fellowship, Inc. under the medical auspices and direction of a local physician, upon consultation with a practicing physician or surgeon to exercise for me and on my behalf, all rights and duties with reference to consenting to appropriate medical, psychiatric, dental and surgical treatment, anesthetics, medicines and hospitalization including care and treatment by any hospital, staff surgeon, physician, radiologist or dentist which they may deem necessary for my care, or son or daughter if under age of 18.

Signature _____
STUDENT (PARENT/GUARDIAN IF STUDENT IS A MINOR)

Date ____ / ____ / ____
MM DD YYYY

Name: _____ Date _____

CONFIDENTIAL PERSONAL HEALTH HISTORY REPORT

Height _____ Weight _____ Explain any significant weight change in past 2 years: _____

Allergies-please specify to what and treatment as needed

Medication: _____

Food/Environmental: _____

Medications-please list any current medications and reason for each: _____

Recent serious injuries, illness, surgical procedures-please explain what and when: _____

Psychiatric history-please explain any therapies by a counselor, psychiatrist, psychologist: _____

Illegal drug use-please explain when and what you used: _____

Please check the following that apply according to your health history. Indicate at what age this occurred and if it is a current problem.

Cardiopulmonary	Yes	Age	Current Problem	Infectious disease	Yes	Age	Current Problem
Asthma	<input type="checkbox"/>	_____	<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	_____	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	_____	<input type="checkbox"/>	Measles	<input type="checkbox"/>	_____	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	_____	<input type="checkbox"/>	Rubella (German measles)	<input type="checkbox"/>	_____	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	_____	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	_____	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	_____	<input type="checkbox"/>	Meningitis	<input type="checkbox"/>	_____	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	_____	<input type="checkbox"/>	Mono	<input type="checkbox"/>	_____	<input type="checkbox"/>
				Malaria	<input type="checkbox"/>	_____	<input type="checkbox"/>
				Rheumatic fever	<input type="checkbox"/>	_____	<input type="checkbox"/>
Metabolic	Yes	Age	Current Problem	Scarlet fever	<input type="checkbox"/>	_____	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	_____	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	_____	<input type="checkbox"/>
Insulin dependent	<input type="checkbox"/>	_____	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	_____	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	_____	<input type="checkbox"/>	Whooping cough	<input type="checkbox"/>	_____	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	_____	<input type="checkbox"/>	HIV positive	<input type="checkbox"/>	_____	<input type="checkbox"/>
				Other _____	<input type="checkbox"/>	_____	<input type="checkbox"/>
Musculoskeletal	Yes	Age	Current Problem	Neuropsychiatric	Yes	Age	Current Problem
Arthritis	<input type="checkbox"/>	_____	<input type="checkbox"/>	Depression	<input type="checkbox"/>	_____	<input type="checkbox"/>
Back problems	<input type="checkbox"/>	_____	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	_____	<input type="checkbox"/>
Fractures	<input type="checkbox"/>	_____	<input type="checkbox"/>	Head Injury	<input type="checkbox"/>	_____	<input type="checkbox"/>
Hernia	<input type="checkbox"/>	_____	<input type="checkbox"/>	Severe Headache	<input type="checkbox"/>	_____	<input type="checkbox"/>
Polio	<input type="checkbox"/>	_____	<input type="checkbox"/>	Mental disorder	<input type="checkbox"/>	_____	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	_____	<input type="checkbox"/>	Drug overdose	<input type="checkbox"/>	_____	<input type="checkbox"/>
				Suicidal acts	<input type="checkbox"/>	_____	<input type="checkbox"/>
				Other _____	<input type="checkbox"/>	_____	<input type="checkbox"/>
Gastrointestinal	Yes	Age	Current Problem				
Irritable Bowel	<input type="checkbox"/>	_____	<input type="checkbox"/>				
Ulcer	<input type="checkbox"/>	_____	<input type="checkbox"/>				
Appendicitis	<input type="checkbox"/>	_____	<input type="checkbox"/>				

Current Physical Limitations: _____

Mailing Instructions:

1. Make sure form is filled out completely following all instructions carefully. Make sure to sign and date front of form in response and consent section.
2. Attach copy of all insurance cards (medical, dental, vision, etc...).
3. Mail health form and appropriate supporting documents to:

New York Campus:
 Health Services
 Word of Life Bible Institute
 PO Box 129
 Pottersville NY 12860-0129

Florida Campus:
 Health Services
 Word of Life Bible Institute
 13001 Word of Life Dr
 Hudson FL 34669