

Mental Health Problems

Has your job, schooling, or military service ever been interrupted because of emotional problems?

Yes No

Have you ever been diagnosed as having an eating disorder such as Anorexia or Bulimia?

Yes No

Have you ever been hospitalized or treated with medication for anxiety, depression, or psychosis?

Yes No

Please explain any "yes" answers _____

Signature

Your signature below signifies that this information is true and complete to the best of your knowledge, and that you realize falsifications may result in your dismissal from Providence Baptist College.

Student Signature _____ Date _____

Parent's Signature _____ Date _____

(Required if applicant is under 18 years of age)

To be completed by Health Care Provider

It is my opinion that _____ is physically capable of performing a typical college students' daily routine.

Physician's signature _____ Date _____

Entrance Health Record



Personal Data

Name _____ Male Female

Mailing Address _____

Home Phone _____ Birth Date _____

Marital Status Single Married Divorced Separated Remarried

Emergency Contact- *In case of emergency, who may we contact?*

Name _____ Phone _____

Address _____

Health Insurance Information

Name of Insurance Company _____

Address _____

Policy Number or Group Number _____ Identification Number _____

Name and address of person on whom the policy is written _____

Student's age at which the policy is no longer effective _____ Student's age now _____

Physician

Name _____

Address _____

Phone _____ Specialty _____

Immunizations

TB PPD (within the last 6 months) Negative Positive (Tine test not acceptable)

If positive, chest x-ray is required. Result _____

Rubella (German Measles) Date Received _____

Rubeolla (Measles) Date Received _____
(1st shot) (2nd shot)

Diphtheria/Pertussis/Tetanus Injections. Date Received:

1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Tetanus Toxoid booster (within 10 years) Date _____

Limitations

Do you have a physical limitation? Yes No

Do you have a known learning disability? Yes No

Will you need any exemptions or special exceptions from the rules of Providence Baptist College? _____

Please explain any yes answer _____

Allergies

Are you allergic to any medications, food or substance? Yes No

If yes, please list each thing to which you are allergic _____

Do you have any dietary restrictions? Yes No If yes, briefly describe below.

Will you need allergy injections while at Providence Baptist College? Yes No

Medications *(on a regular basis)*

Please list medications, doses, and reasons for taking. _____

Will you need injections while at Providence Baptist College? Yes No

Type? _____

Medical Problems *(please list all previous and present medical problems)*

Hospitalizations- *please include diagnosis and dates*

Surgeries- *Please include name of operation(s) and date(s).*

Injuries- *Please include bodily injuries, complications, types of accidents and permanent disabilities. Give dates.*

Personal Health Problems

Have you ever used any illegal, indictable, or recreational drugs (to include marijuana)? Yes No

If so, please list types, approximate length of usage, and when last used. _____

Have you ever used alcohol of any kind? Yes No

If you have partaken in alcohol beverages, please list approximate length of usage and when last used.

Problem History

Have you had or presently do you have any of the following?

- | | | | |
|--------------------------|--|--------------------------|--|
| Yes | No | Yes | No |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Allergy | | Hepatitis (If yes, type _____) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Anemia (including sickle cell anemia) | | High blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Asthma | | Hypoglycemia |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Bleeding disorder | | Infectious mononucleosis (past 6 months) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Blindness (complete or partial) | | Kidney infection or stone |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Cancer (including leukemia, etc.) | | Malaria |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Cystic Fibrosis | | Migraine headache |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Diabetes: <input type="checkbox"/> Insulin | | Parasitic disease |
| | <input type="checkbox"/> Diet control | <input type="checkbox"/> | <input type="checkbox"/> |
| | <input type="checkbox"/> Oral medication | | Pneumonia |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Dysentery | | Polyps of colon |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Epilepsy or other seizure disorder | | Rheumatoid arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Glaucoma | | Rheumatoid fever |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Hearing loss (complete or partial) | | STD's (Syphilis, Gonorrhea, AIDS, etc.) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Heart disease | | Thyroid trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Herpes | | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | | |
| | Heart murmur | | |
| <input type="checkbox"/> | <input type="checkbox"/> | | |
| | Heart valve problem | | |

Please comment on any "yes" answers _____