Bethlehem
Education in Serious Joy®

MEDICAL INFORMATION & HEALTH HISTORY FORM

LEGAL NAME

FIRST ______________________________ MIDDLE ______________________

LAST ______________________________ DATE OF BIRTH ______________________

EMERGENCY CONTACT INFORMATION

PARENTS/LEGAL GUARDIAN ____

ADDRESS ____

HOME PHONE ______________________ WORK PHONE ______________________

CELL PHONE ______________________ EMAIL______________________

EMERGENCY CONTACT (OTHER THAN PARENT/GUARDIAN)

NAME ____

RELATIONSHIP ____

PHONE ____

- -

HEALTH CONCERNS OR ALLERGIES ____

____

In the event of an illness, injury, or emergency, I give Bethlehem College & Seminary permission to proper medical treatment for myself including transportation and hospitalization, if necessary, should my emergency contacts not be able to be reached.

PRINTED NAME ______________________________ DATE ______________________

SIGNATURE ____

HEALTH HISTORY

All students are required to complete the Health History form and the Immunization Record and submit it promptly to the Registrar's office. Certain Immunizations (MMR [measles, mumps, rubella] and Td [tetanus, diphtheria] or Tdap [tetanus, diphtheria, pertussis] are required by the state of Minnesota for Bethlehem College & Seminary to have on record within 45 calendar days after the start of the student's first semester. If the Registrar's office has not received your completed form within the 45-day deadline, a "hold" will be placed on your record and you will not be able to register for the subsequent semester. This Health History information is restricted and will not be released to anyone without your consent.

FULL LEGAL NAME (L, F, M) ______________________________

PERMANENT ADDRESS ______________________________

____

TELEPHONE ____________________ EMAIL____________________

DATE OF BIRTH ____________________ PLACE OF BIRTH ____________________

MARITAL STATUS ____________________ SEX ____________________

HEIGHT ____________________ WEIGHT ____________________

PHYSICIAN INFORMATION

DOCTOR'S NAME ______________________________

ADDRESS ______________________________

____

PHONE ______________________________

*A doctor's examination within six months of enrollment is **recommended** particularly for a student with a chronic or serious condition that presents any potential need for health care.*

A photocopy (front and back) of your health and dental cards are required to be submitted with this completed form.

FAMILY HISTORY

NAME OF PARENT/GUARDIAN/NEXT OF KIN ______________________________

RELATIONSHIP ______________________________

ADDRESS ______________________________

CELL TELEPHONE NO. ____________________ WORK TELEPHONE NO. ____________________

EMAIL ______________________________

Give age and present health of parents and siblings. (If deceased, give age at death and cause of death.)

FATHER	MOTHER
BROTHERS	SISTERS

Is there a history of tuberculosis, diabetes, epilepsy, cancer, and/or mental illness (e.g., depression, bipolar, schizophrenia) in your immediate family? [Circle any that apply and note relationship.]

PERSONAL MEDICAL HISTORY

Check the following illnesses or injuries that you have had. State at what age.

☐ MEASELS (RED) ________	☐ DIABETES ________	☐ ASTHMA ________
☐ MEASELS (GERMAN) ________	☐ SEIZURES ________	☐ TUBERCULOSIS ________
☐ MUMPS ________	☐ HEART TROUBLE ________	☐ ARTHRITIS ________
☐ CHICKEN POX ________	☐ KIDNEY TROUBLE ________	☐ EATING DISORDER ________

List any other chronic or serious illness(es) you have had. ________

List and give date of any operation(s) you have had. ________

Do you have a permanent physical disability? If so, what? ________

Have you ever had an allergic reaction to any kind of drug? (State name of drug) ________

Have you ever had an allergic reaction to any food, insect bite, etc. (Name, explain) ________

Are you presently taking any medicine? (Name, dosage) ________

Have you ever been hospitalized? (Reason, date) ________

Have you ever had a head injury or loss of consciousness? (Date, extent) ________

Have you ever been told by a physician that you have anything wrong with your heart? If so, what? ________

General condition of your physical health in your opinion: ☐ GOOD ☐ FAIR ☐ POOR

Is there any reason for restriction of activity? If so, what? ______________________________

Any additional information BCS should have regarding your physical health? ______________________________

____

____

PERSONAL EMOTIONAL/MENTAL HEALTH HISTORY

Use separate sheet to provide complete details for all "Yes" answers to the following:

Have you ever received treatment or counseling more than three times for psychological or emotional problem? ☐ YES ☐ NO

Currently Have you ever been hospitalized for psychiatric care? ☐ YES ☐ NO

Have you ever been treated for anxiety/depression? ☐ YES ☐ NO

Have you ever been treated for insomnia? ☐ YES ☐ NO

Have you ever been treated for an eating disorder? ☐ YES ☐ NO

Have you ever been treated for alcohol or drug dependency? ☐ YES ☐ NO

Have you ever attempted suicide? ☐ YES ☐ NO

Any additional information BCS should have regarding your emotional and mental health? ______________________________

____

____