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/EMAIL

- -

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.

☐ MEASLES (RED) _____ ☐ DIABETES _____ ☐ ASTHMA _____

☐ MEASLES (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? _____

_____

_____