

NEW ENGLAND BAPTIST COLLEGE

STUDENT HEALTH PROFILE

PERSONAL INFORMATION

Name _____ Date of Birth _____
Address _____ Apt. _____
City _____ State _____ Zip _____

EMERGENCY CONTACT

Name _____ Phone () _____
Address _____ Apt. _____
City _____ State _____ Zip _____

INSURANCE INFORMATION *(required prior to registration)*

Company _____ Group/Policy _____
Policyholder _____ S.S. # _____
(All dormitory students are required to have hospitalization insurance.)

GENERAL INFORMATION

1. If health insurance is needed, hospital/surgical insurance is available. The premium must be paid at the beginning of each semester.
2. Prescription medications taken regularly require a written physician's explanation.

PREVIOUS PHYSICIANS

Name _____ Specialty _____
Address _____ City _____ State _____ Zip Code _____

Name _____ Specialty _____
Address _____ City _____ State _____ Zip Code _____

LIMITATIONS

Do you have a physical limitation or a known learning disability? Yes No

If so, please explain. _____

STUDENT HEALTH PROFILE

IMMUNIZATIONS (required prior to attendance)

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

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

Rubella (German Measles) Date Received _____

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

Diphtheria / Pertussis / Tetanus injections. Dates Received:

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

Tetanus Toxoid booster (within 10 years) Date: _____

Meningitis Vaccination (required for all dormitory students in CT) _____

ALLERGIES

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

If yes, please specify each allergy. _____

Will you need allergy injections during the semester? Yes No

MEDICATIONS

List prescriptions medications used on a regular basis, doses, and reasons for taking. _____

Will you need injections while attending New England Baptist College? Yes No

If so, specify the type of injection. _____

PREVIOUS AND PRESENT MEDICAL PROBLEMS

Hospitalizations - Please include diagnosis and dates. _____

Surgeries - Please include type of operation(s) and dates. _____

Injuries - Please include type, complications, any permanent disabilities and dates. _____

MENTAL HEALTH

Yes No

- Has your job or schooling ever been interrupted because of emotional problems?
- Have you ever been diagnosed with an eating disorder such as anorexia or bulimia?
- Have you ever been hospitalized or treated for anxiety, depression, or psychosis?

Explain any "Yes" answers. _____

STUDENT HEALTH PROFILE

Page 3 of 3

PREVIOUS AND PRESENT MEDICAL PROBLEMS *(continued)*

Have you ever used any illegal, injectable, or recreational drugs? Yes No
If so, list the type of drug, approximate length of usage, and when last used. _____

Have you ever used alcohol on a regular basis? Yes No
If so, please list approximate length of usage and when last used. _____

MEDICAL HISTORY *(check any condition you presently or previously have suffered)*

- | | | | |
|--------------------------|---|--------------------------|---|
| Yes | No | Yes | No |
| <input type="checkbox"/> | <input type="checkbox"/> Allergy | <input type="checkbox"/> | <input type="checkbox"/> Heart valve problem |
| <input type="checkbox"/> | <input type="checkbox"/> Anemia (including sickle cell anemia) | <input type="checkbox"/> | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> Asthma | <input type="checkbox"/> | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> Blindness (complete or partial) | <input type="checkbox"/> | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> | <input type="checkbox"/> Cancer (including Leukemia, Hodgkin's disease) | <input type="checkbox"/> | <input type="checkbox"/> Infectious mononucleosis (past 6 months) |
| <input type="checkbox"/> | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> | <input type="checkbox"/> Kidney infection or stone |
| <input type="checkbox"/> | <input type="checkbox"/> Diabetes | <input type="checkbox"/> | <input type="checkbox"/> Malaria |
| <input type="checkbox"/> | <input type="checkbox"/> Diet Control | <input type="checkbox"/> | <input type="checkbox"/> Migraine headaches |
| <input type="checkbox"/> | <input type="checkbox"/> Insulin | <input type="checkbox"/> | <input type="checkbox"/> Parasitic disease _____ |
| <input type="checkbox"/> | <input type="checkbox"/> Oral Medication | <input type="checkbox"/> | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> | <input type="checkbox"/> Dysentery | <input type="checkbox"/> | <input type="checkbox"/> Polyps of the colon |
| <input type="checkbox"/> | <input type="checkbox"/> Epilepsy or other seizure disorder | <input type="checkbox"/> | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> Hearing loss (complete or partial) | <input type="checkbox"/> | <input type="checkbox"/> Stomach ulcers |
| <input type="checkbox"/> | <input type="checkbox"/> Heart disease | <input type="checkbox"/> | <input type="checkbox"/> Thyroid trouble |
| <input type="checkbox"/> | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> | <input type="checkbox"/> Tuberculosis |

Give details for any "Yes" answers. _____

