# New England Baptist College

# Student Health Profile

## Personal Information

DATE:___/___/___

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

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. _____

_____

1541 West Street ✵ Southington, CT 06489
860-621-6701 ✵ nebc@centralbaptistchurch.net

## 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 _____

MMR 1st shot Date Received _____ 2nd shot Date Received _____

Varicella (Chickenpox) 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. _____

## SPECIAL DIETARY NEEDS

Please describe special requirements. (*Verification from a physician may be necessary*)

_____

_____

_____

## 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. _____

_____

## 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 | |
|---|---|---|---|---|---|
| ❑ | ❑ | Allergy | ❑ | ❑ | Heart valve problem |
| ❑ | ❑ | Anemia (including sickle cell anemia) | ❑ | ❑ | Hepatitis |
| ❑ | ❑ | Asthma | ❑ | ❑ | Herpes |
| ❑ | ❑ | Bleeding disorder | ❑ | ❑ | High blood pressure |
| ❑ | ❑ | Blindness (complete or partial) | ❑ | ❑ | Hypoglycemia |
| ❑ | ❑ | Cancer (including Leukemia, Hodgkin's disease) | ❑ | ❑ | Infectious mononucleosis (past 6 months) |
| ❑ | ❑ | Cystic Fibrosis | ❑ | ❑ | Kidney infection or stone |
| ❑ | ❑ | Diabetes | ❑ | ❑ | Malaria |
| ❑ | ❑ | Diet Control | ❑ | ❑ | Migraine headaches |
| ❑ | ❑ | Insulin | ❑ | ❑ | Parasitic disease _____ |
| ❑ | ❑ | Oral Medication | ❑ | ❑ | Pneumonia |
| ❑ | ❑ | Dysentery | ❑ | ❑ | Polyps of the colon |
| ❑ | ❑ | Epilepsy or other seizure disorder | ❑ | ❑ | Rheumatic fever |
| ❑ | ❑ | Glaucoma | ❑ | ❑ | Rheumatoid arthritis |
| ❑ | ❑ | Hearing loss (complete or partial) | ❑ | ❑ | Stomach ulcers |
| ❑ | ❑ | Heart disease | ❑ | ❑ | Thyroid trouble |
| ❑ | ❑ | Heart murmur | ❑ | ❑ | Tuberculosis |

Give details for any "Yes" answers. _____

_____

_____

_____