Confidential Medical History Form

Keystone School of Biblical Theology
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Last Name_____ First_____ Middle_____

Date of Birth _____ Please circle: Married Single Male Female

Part 1- Medical History

Please check if you have had any of the following:

[ ] Amoebic Dysentery
[ ] Appendicitis
[ ] Chicken Pox
[ ] Diphtheria
[ ] German Measles
[ ] Hepatitis
[ ] Mumps
[ ] Mononucleosis
[ ] Influenza
[ ] Kidney Infection
[ ] Malaria
[ ] Pleurisy
[ ] Typhoid Fever
[ ] Measles
[ ] Rheumatic Fever
[ ] Scarlet Fever
[ ] Skin Disease
[ ] Strep Throat
[ ] Tonsillitis
[ ] Tuberculosis
[ ] Stomach Ulcers/GERD
[ ] Sexually Transmitted Disease
[ ] Whooping Cough
[ ] Other
_____

Have you had or do you have now any of the following:

[ ] Asthma (If symptoms in past two years, bring updated inhaler)
[ ] Diabetes
[ ] Excessive Fatigue
[ ] Hay Fever
[ ] Digestive disorders
[ ] Nervous disorders
[ ] Constipation
[ ] Epilepsy
[ ] AIDS/HIV
[ ] Hypoglycemia
[ ] Sinus Condition
[ ] Migraine Headaches
[ ] Anorexia/Bulimia
[ ] Fainting Spells
[ ] Food Allergies
[ ] Seizures

Important - If you have checked any item above, please list each separately on another sheet of paper and state your current treatment and/ or prevention.

Injuries or surgeries

Broken bones: When? _____ What type? _____

Tonsillectomy: When? _____

Appendectomy: When? _____

Has any member of your family had:

[ ] Heart Disease [ ] Cancer [ ] Diabetes [ ] Tuberculosis

Is your father living? **Yes** or **No** If no, date deceased: _____ Cause of death: _____

Is your mother living? **Yes** or **No** If no, date deceased: _____ Cause of death:_____

Any siblings deceased? **Yes** or **No** If yes, date deceased: _____ Cause of death:_____

Part II – Immunization Record

List original inoculations and boosters with month/day/year or **attach shot record (preferred)**

DPT/DT (5 Baseline) _____ _____ _____ _____ _____

Hepatitis B (3 required) _____ _____ _____

MMR (2 required) _____ _____

Tdap _____ or last other tetanus booster _____

Meningococcal _____ _____ _____

Varicella (Chicken Pox) 2 vaccinations _____ _____ or last year of known disease _____

Have you ever had a positive TB skin test? If so, please explain: _____

_____

Do you have any known food or environmental allergies? Please be specific. _____

_____

What is your current treatment for this condition? (shots, oral meds, etc.) _____

_____

Do you have any dietary problems? _____ Type _____

Are you on any medication? _____ if so, name the medicine_____

Reason for using the medication _____

Do you have any known medication allergies? If, so to what? _____

Do you have any disabilities? _____ if so, describe _____

Have you ever been under psychiatric treatment? _____

Have you ever been a patient in a mental hospital _____ If so, how long? _____

Has any close family member suffered from this difficulty? _____

If so, state the relationship with you _____

I hereby certify that the above information is complete to the best of my or my parent's knowledge. I hereby authorize Keystone School of Biblical Theology to inform the faculty and/or staff, and any health provider I may go to, of any health information that is deemed appropriate and necessary. I also give permission for the Keystone School of Biblical Theology to speak to my parents/guardian about my medical information.

New Student:	**Parent/Guardian (if under 18)**
_____	_____
Signature of New Student	Signature of Parent/Guardian
_____	_____
Street Address	Street Address (if different from new student)
_____	_____
City State Zip	City State Zip
_____	_____
Home Phone	Home Phone/cell phone

Authorization for Medical and Surgical Treatment

I, _____, the legal parent or guardian of _____, who is under 18 years of age, hereby authorize a representative of Keystone School of Biblical Theology to sign consent papers for medical treatment in the event of an emergency and to administer over the counter medication as appropriate and necessary.

Signature:_____ Date _____