Medical History

(To be completed by applicant)
Please complete BOTH SIDES of this form

Completion of this form is a preliminary step and does not imply acceptance.
Final action will be taken and you will be notified after references, etc. have been received by Frontier.

Name ________________________ Birth date ______________ Height _____ Weight ______

IN CASE OF AN EMERGENCY, NOTIFY:

Name ________________________ Relationship ______________ Phone # __________

Address ________________________ City ______________ State _____ Zip _____

DOCTOR:
Name ____ Phone # __________

Clinic ____

Address ________________________ City ______________ State _____ Zip _____

1. If you had any of the following, indicate age: (Example: ____5____ Mumps) AND give explanation on back of this sheet.

_____ Anemia
_____ Chicken Pox
_____ Diphtheria
_____ Dysentery
_____ Discharge from ears
_____ German Measles
_____ Goiter
_____ Hearing Problems
_____ Jaundice
_____ Kidney Disease
_____ Malaria
_____ Measles
_____ Mumps
_____ Muscle Disorder
_____ Nerve Disorder
_____ Pneumonia
_____ Rheumatic Fever
_____ Seizures
_____ Scarlet Fever
_____ Tonsillitis
_____ Typhoid or Paratyphoid
_____ Venereal Disease
_____ Whooping Cough
_____ Other (explain on back)

2. If you have any of the following, check those that apply AND give explanation on back of this sheet.

_____ Asthma
_____ Cancer
_____ Diabetes
_____ Dizzy Spells
_____ Epilepsy
_____ Fainting Spells
_____ Frequent Colds
_____ Frequent Constipation
_____ Frequent Diarrhea
_____ Frequent Indigestion
_____ Frequent Sore Throat
_____ Gall Bladder Trouble
_____ Hay Fever
_____ Heart Murmur
_____ Hemorrhoids
_____ Hernia
_____ Hypertension
_____ Hyperthyroidism
_____ Hypoglycemia
_____ Hypothyroidism
_____ Kidney or Bladder Trouble
_____ Liver Trouble
_____ Lupus
_____ Migraine Headaches
_____ Momentary Loss of Consciousness
_____ Pain in Chest
_____ Pain in Joints
_____ Pleurisy
_____ Rapid Pulse
_____ Significant Weight Change
_____ Sinusitis
_____ Shortness of Breath
_____ Sleep Disorder
_____ Ulcers
_____ Other – explain on back

3. If you had any of the following, <u>check, then give dates and facts on the back of this sheet</u>.

_____Brain concussions or skull fractures
_____Pus, blood, or sugar in the urine
_____Significant accidents or injuries
_____ Coughing up blood
_____ Pus, blood or mucus in the bowel movements
_____ Significant surgeries

4. Do you have any allergies? _____ Yes ____ No If yes, list them and describe reactions on the back of this sheet.

5. Have you had serious bouts of depression? _____ Yes _____ No If yes, explain on the back of this sheet.

6. Do you currently have or have you previously had any of the following emotional or behavioral disorders? Check all that apply and give an explanation on back of this sheet.

_____ ADD
_____ ADHD
_____ Bi-Polar
_____ Depression (explain below)
_____ Eating Disorder
_____ Manic Depressive
_____ Schizophrenia
_____ Other (explain below)

Are you on medication for disorder(s) listed above? List medications: ______________________

____

CONTINUED ON BACK SIDE

Have you ever seen a counselor in regard to disorder(s) checked above? _________ YES _____ NO

If yes, give dates: ____

7. Do you take any medication regularly or periodically (including over the counter products)? _______ Yes _____ No If yes, give name of medication, dosage, and reason below.

8. Do you have any serious health problems not mentioned above or problems that could be a hindrance to your education at Frontier? _____ Yes _____ No If yes, explain below.

9. ***RECOMMENDED IMMUNIZATIONS***

The following immunizations are recommended to lessen the risk of certain contagious diseases.

Tetanus – Diphtheria – primary series (4) plus booster (1)

Primary series with DTaP or DTP __________#1__________#2__________#3__________#4 (give dates)

TD or TDAP Booster __________#1 (within last 10 years - give date)

Hepatitis B (3 shot series) _________#1_________#2_________#3 (give dates)

Poliomyelitis (4-5 doses) __________#1__________#2__________#3__________#4__________#5 (give dates)

Meningococcal / MCV4 (1) _______ (give date)

TB Test (within last 12 months) __________ (give dates)

10. ***REQUIRED IMMUNIZATION*** *– MMR*

Frontier School of the Bible requires each incoming student to be protected against measles, mumps, and rubella. Receipt of 2 MMR (Measles, Mumps, and Rubella) vaccinations **REQUIRES SIGNATURE OF MEDICAL PROVIDER**

MMR #1__________(date) MMR #2__________(date)

____ _________________

Signature of medical provider Date