Word of Life Bible Institute
A Great Place To Start

Health Record

Entered: ☐ Fall ☐ Spring Year: ____________

STUDENT INFORMATION

Name______________________________ DOB___/___/_____ SSN_____-____-_____
LAST FIRST MIDDLE MM DD YYYY

Address: ____
STREET/ROAD/BOX# CITY STATE POSTAL CODE COUNTRY

Gender: ☐ Male ☐ Female Cell (___)_____-_______ Email:______________

EMERGENCY CONTACT INFORMATION

Circle One: Parent Guardian Spouse Name:______________________ Cell: (___)_____-______
LAST FIRST

Address: ______________________________________ Home: (___)_____-______
STREET/ROAD/BOX#

____
CITY STATE POSTAL CODE COUNTRY

IMMUNIZATION RECORD

Immunizations required for enrollment: must be completed & signed by health care professional or attach official copies with stamp or letterhead from your health care provider or high school. Attach medical or religious waiver complaint with the laws of NY/FL where applicable. ***All immunization documentation must be in English language.***

Immunization Record: MMR and current tetanus are required. ***If you have not had the Hepatitis B or Meningitis vaccinations you must complete the waiver below before signing the health form and submitting it.***

	MMR	Most recent Tetanus (Td/Tdap)	Meningitis	Hepatitis B
Dose 1				
Dose 2				
Dose 3				

Mantoux Tuberculosis Skin Test: TB skin test (and x-ray if test is positive) must be within 1yr of admission.

Date of last TB skin test: ___/___/_____ Results: ________mm induration. If positive provide chest x-ray documentation
MM DD YYYY

Have you ever been treated for tuberculosis? ☐ Yes ☐ No Have you received the BCG vaccine? ☐ Yes ___/___/_____ ☐ No
MM DD YYYY

Health Care Provider: Complete the above information, sign and date

____ ___/___/_____
PRINT NAME AND TITLE SIGNATURE DATE: MM DD YYYY

INSURANCE INFORMATION

Do you have Health Insurance? ☐ Yes ☐ No Name of provider:______________________

ATTACH COPY OF INSURANCE CARDS

RESPONSE AND CONSENT

Check one statement regarding Meningococcal Meningitis if you have not had the vaccine:

☐ I have (my child has) read, or have had explained to me information regarding meningococcal meningitis disease. I (my child) will obtain immunization against meningococcal meningitis within 30 days of the first day of class from my private health care provider or Word of Life Bible Institute health center will facilitate the immunization via a local physician's office.

☐ I have (my child has) read, or have had explained to me information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I (my child) will not obtain immunization against meningococcal meningitis disease.

Check one statement regarding Hepatitis B if you have not had the vaccine:

☐ I have (my child has) read, or have had explained to me information regarding Hepatitis B disease. I (my child) will obtain immunization against Hepatitis B within 30 days of the first day of class from my private health care provider or Word of Life Bible Institute health center will facilitate the immunization via a local physician's office.

☐ I have (my child has) read, or have had explained to me information regarding Hepatitis B disease. I understand the risks of not receiving the vaccine. I have decided that I (my child) will not obtain immunization against Hepatitis B disease.

Read and sign:

I hereby authorize the Health Care Staff at Word of Life Fellowship, Inc. under the medical auspices and direction of a local physician, upon consultation with a practicing physician or surgeon to exercise for me and on my behalf, all rights and duties with reference to consenting to appropriate medical, psychiatric, dental and surgical treatment, anesthetics, medicines and hospitalization including care and treatment by any hospital, staff surgeon, physician, radiologist or dentist which they may deem necessary for my care, or son or daughter if under age of 18.

Signature______________________________ Date___/___/_____
STUDENT (PARENT/GUARDIAN IF STUDENT IS A MINOR) MM DD YYYY

Continued →

Name:_______________________________ Date_______________

CONFIDENTIAL PERSONAL HEALTH HISTORY REPORT

Height __________Weight __________ Explain any significant weight change in past 2 years:______________________

Allergies-please specify to what and treatment as needed

Medication: ______________________________

Food/Environmental: ______________________________

Medications-please list any current medications and reason for each:______________________________

____

Recent serious injuries, illness, surgical procedures-please explain what and when: ______________________________

____

Psychiatric history-please explain any therapies by a counselor, psychiatrist, psychologist: ______________________________

____

Illegal drug use-please explain when and what you used: ______________________________

____

Please check the following that apply according to your health history. Indicate at what age this occurred and if it is a current problem.

Cardiopulmonary	Yes	Age	Current Problem
Asthma	☐	____	☐
Heart Disease	☐	____	☐
Heart Murmur	☐	____	☐
High Blood Pressure	☐	____	☐
Pneumonia	☐	____	☐
Other ____________	☐	____	☐

Metabolic	Yes	Age	Current Problem
Diabetes	☐	____	☐
Insulin dependent	☐	____	☐
Thyroid problems	☐	____	☐
Other ____________	☐	____	☐

Musculoskeletal	Yes	Age	Current Problem
Arthritis	☐	____	☐
Back problems	☐	____	☐
Fractures	☐	____	☐
Hernia	☐	____	☐
Polio	☐	____	☐
Other ____________	☐	____	☐

Gastrointestinal	Yes	Age	Current Problem
Irritable Bowel	☐	____	☐
Ulcer	☐	____	☐
Appendicitis	☐	____	☐

Infectious disease	Yes	Age	Current Problem
Chicken Pox	☐	____	☐
Measles	☐	____	☐
Rubella (German measles)	☐	____	☐
Mumps	☐	____	☐
Meningitis	☐	____	☐
Mono	☐	____	☐
Malaria	☐	____	☐
Rheumatic fever	☐	____	☐
Scarlet fever	☐	____	☐
Tuberculosis	☐	____	☐
Hepatitis	☐	____	☐
Whooping cough	☐	____	☐
HIV positive	☐	____	☐
Other ____________	☐	____	☐

Neuropsychiatric	Yes	Age	Current Problem
Depression	☐	____	☐
Epilepsy	☐	____	☐
Head Injury	☐	____	☐
Severe Headache	☐	____	☐
Mental disorder	☐	____	☐
Drug overdose	☐	____	☐
Suicidal acts	☐	____	☐
Other ____________	☐	____	☐

Current Physical Limitations: ________________

____

____

Mailing Instructions:

1. Make sure form is filled out completely following all instructions carefully. Make sure to sign and date front of form in response and consent section.
2. Attach copy of all insurance cards (medical, dental, vision, etc…).
3. Mail health form and appropriate supporting documents to:

New York Campus:

Health Services
Word of Life Bible Institute
PO Box 129
Pottersville NY 12860-0129

Florida Campus:

Health Services
Word of Life Bible Institute
13001 Word of Life Dr
Hudson FL 34669

WORD OF LIFE FELLOWSHIP
STUDENT ACCIDENT INSURANCE
ENROLLMENT FORM

All Students: Fill out completely. Print in blue or black ink or type. No nicknames (of people or towns).

Name	Sex ❑ Male ❑ Female	Date of Birth
Street Address	Home Phone No	Work Phone No
City, State, Zip	Social Security No	

ENROLLMENT

❑ Automatic Student Accident Plan

EFFECTIVE DATE OF THIS STUDENT COVERAGE:____________________

SECTION 2: OTHER INSURANCE

Are you covered under a health insurance plan (including Medicare or Medicaid)? ☐ Yes ☐ No

If yes, please provide the following information in order to assure accurate and timely processing of your claims.

Health Insurance Co. Name	Health Insurance Co. Address & Phone No

Policy Holder Name	Policy No	Group Policy
Effective Date	Type of Coverage ☐ Single ☐ 2 Person ☐ Family	

SECTION 3: OTHER INSURANCE

Are you covered under another health or dental insurance plan (including Medicare or Medicaid)? ☐Yes ☐ No

If yes, please provide the following information in order to assure accurate and timely processing of your claims.

Health Insurance Co. Name	Health Insurance Co. Address & Phone No

Policy Holder Name	Policy No	Group Policy
Effective Date	Type of Coverage ☐ Single ☐ 2 Person ☐ Family	

SECTION 4: SIGNATURE

I certify that the statements on this enrollment form and all information furnished by me are true and complete to the best of my knowledge. I authorize any healthcare provider to disclose to Blue Shield of Northeastern NY or its designated agent, any information acquired in connection with my past or future care or treatment.

Student Signature____ **Date**___________________

Word of Life Authorizing Signature________________________ **Date**___________________

Revised 04/30/04